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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will prepare original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is the aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems will find the magazine of especial interest.

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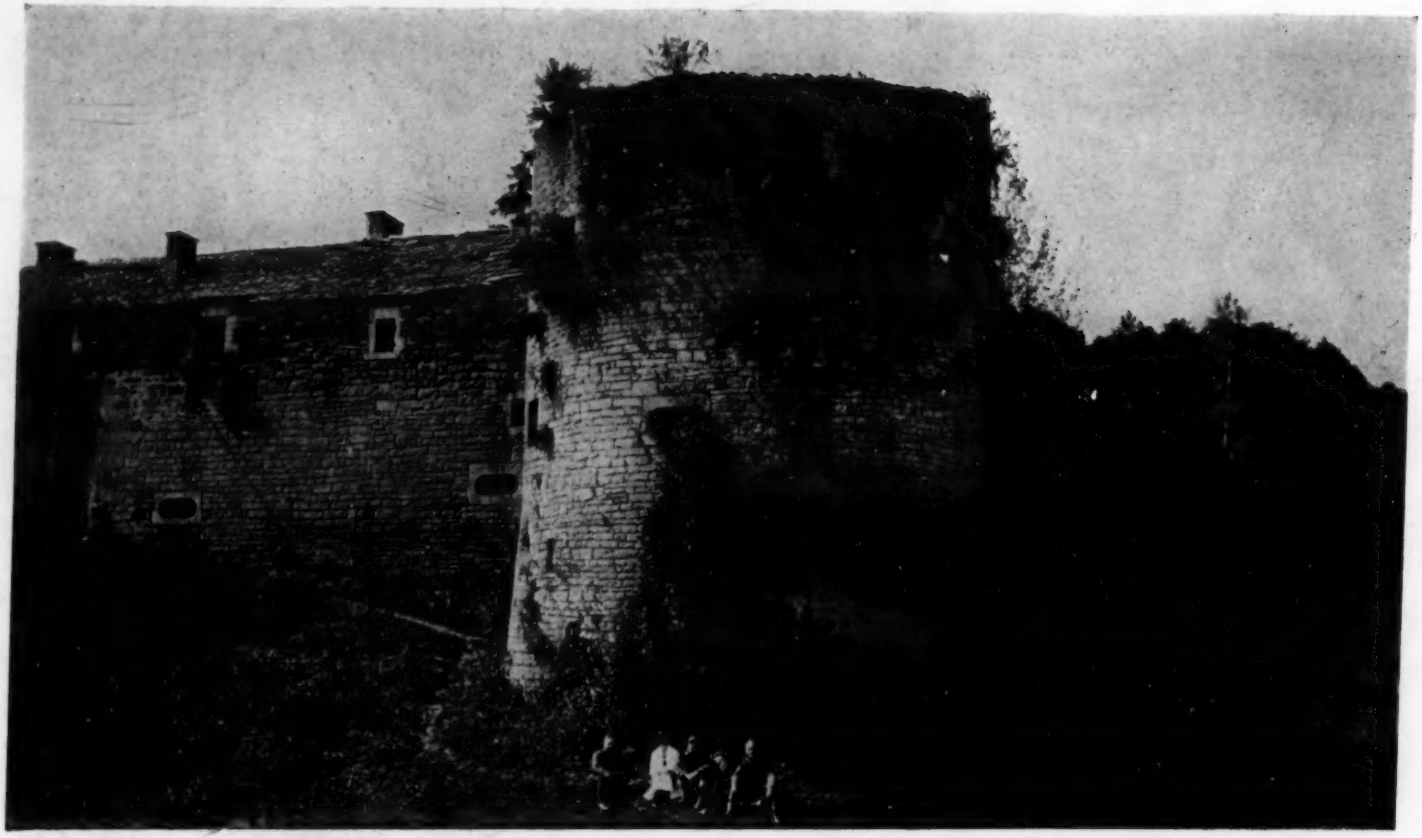

Castle of the Barons of LaFauche on the heights overlooking Base Hospital 117

MENTAL HYGIENE

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MENTAL DEFECT IN A SOUTHERN STATE*

REPORT OF THE GEORGIA COMMISSION ON FEEBLEMINDEDNESS AND THE SURVEY OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

Prepared with the assistance of

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OF the states of the Union that are seeking to find a solution of the ever-increasing and urgent problem of feeblemindedness, Georgia promises soon to be one.

That her past policy of indifference and neglect toward this group, probably the most important single group with which a state needs to concern itself, has given way to an awakened interest is attested by the creation, through the Legislature of 1918, of a special commission to investigate the serious consequences of the state's failure to provide proper care and training for this class of persons.

It is not necessary in this connection to emphasize the striking growth throughout the United States of the movement to make

* In response to a resolution passed by the General Assembly of Georgia at its 1918 session, the Hon. Hugh M. Dorsey, Governor of Georgia, appointed a committee to investigate and "report such facts and figures as they may secure and make such recommendations as may seem to them suitable to relieve the state of the menace of the uncared-for feebleminded." The committee was composed of the Hon. W. E. Thomas, chairman, Hon. W. B. Baker, Hon. W. F. Crusselle, Hon. J. S. Shingler, Hon. Rhoda Kaufman and, *ex-officio*, Hon. M. L. Brittain and Dr. T. F. Abercrombie. At the request of the committee, The National Committee for Mental Hygiene furnished, as scientific adviser to the committee, Dr. V. V. Anderson, who conducted the survey, and his assistant, Miss Carotta Alexander.

provision for feebleminded persons. Suffice it that state-wide surveys, special investigations, and prolonged, painstaking, thoroughgoing scientific researches have demonstrated the positive and close relationship of feeblemindedness to many of society's most serious social problems, and have pointed the way to a possible solution of, or at least a scientific and intelligent approach to, the problems of crime and pauperism, juvenile vice, prostitution, venereal disease, etc.

Because of increased knowledge as to the potency of mental defect as a causative factor underlying crime and much of human wretchedness and misery, larger and larger portions of the public budgets in various states of the Union are going into the organization of preventive measures in dealing with these antisocial problems, rather than, as was the old method, into futile later attempts at treatment and cure.

During the last twenty-odd years, provision for the feebleminded has increased in the United States 750 per cent. One after another the various states of the Union have assumed their places in the ranks of those that seek to provide for this most helpless and potentially dangerous class. Not a single institution created for this purpose has ever been abandoned; on the contrary—and this is most significant—all such institutions have long waiting lists, sometimes running up into the thousands, of applicants for care and training.

Georgia is now one of the very few states that have neglected to make any provision for the mentally defective. Even such care as these mentally defective children are receiving is being given after it is too late and they have become so-called "criminals," or juvenile delinquents, or prostitutes, or paupers, or vagrants, or insane persons. These are problems which Georgia recognizes, and for the handling of which she is spending vast sums of money in courts, jails, stockades, venereal clinics, industrial training schools, reformatories, state prison, almshouses, and the like. This is rather as if a community should go to great expense to build a modern hospital at the foot of a cliff, to take care of those who fall over, instead of putting into effect measures to prevent such accidents.

It was thought that an investigation into these existing institutions in the state might furnish interesting and profitable data, indicating what sort of a problem feeblemindedness is to Georgia and throwing light upon the costliness and extravagance of hand-

ling the final results of mental deficiency, of taking care of the human wreckage found in brothels, almshouses, etc.

In this connection, we set about making a state-wide survey that would throw light on the relationship of feebleminded-ness to juvenile vice and delinquency, as seen in the juvenile court, the State Reformatory for Boys, the Fulton County Reformatory for Boys, and the Georgia Industrial Training School for Girls; to adult crime, vagrancy, and the like, studied in the inmates of the state prison and representative county jails; to prostitution and the spread of venereal diseases, studied in connection with girls arrested for offences against chastity; to pauperism and dependency, studied in typical degenerate families, cases of outdoor relief, and inmates of selected orphanages and almshouses; and finally to education, studied in school children so selected that they would be likely to represent the average school child of Georgia. In this we relied upon the advice and help of the Department of Education.

This method of approaching the problem of surveying feeble-mindedness, it was thought, would give more satisfactory results than an ordinary attempt at a census, because the time at our disposal was so short, and the amount of technically trained help was so limited, as to preclude anything like a satisfactory census of the total number of feebleminded persons in Georgia in need of institutional care.

Methods Employed

The methods employed in our investigation were as follows:

I. Selection of type of cases needing examination

In no instance did we assume that one individual rather than another, in jail, reformatory, prison, court, orphanage, or school, needed an examination. In no instance did we rely upon personal opinion or general observation to tell us who should or who should not be examined. In each and every case in the juvenile court, in the Industrial Training School for Girls, the State Reformatory for Boys, the Fulton County Reformatory for Boys, the state prison, the county jails, the orphanages, and the public schools visited, a systematic mental examination was given.

II. Character of mental examination given to each individual

Attached to each case record was a history blank. This blank contained data bearing upon the medical, criminal, alcoholic,

dependent, etc., history of members of the individual's immediate family. It contained also data on the individual's personal history—developmental facts, both physical and mental; diseases, injuries, etc., affecting the individual during the course of his life, and his present state of physical health; age at which he entered and left school, and grade reached; if in school, the grade and type of work done; the conduct and behavior, including the delinquent history, of the individual, his employment record, particularly statements as to whether he had been regularly or irregularly employed, whether he had only followed odd jobs, or whether he had never done any work or had merely done housework at home; finally, whatever facts could be gathered bearing upon the personality make-up, the mental traits and characteristics, temperamental difficulties, etc., of the individual examined.

This history, in each case, was obtained partly from the individual and partly from the institutional authorities. In the case of the school children, the teacher was relied upon to furnish whatever information it was possible to secure. To be sure, by this method we did not have as well-rounded studies of the careers, particularly of our delinquents, as was desirable, but the data secured we found most helpful in our final diagnosis of the case.

Following the history, a psychiatric examination was given, on the one hand ruling out or eliciting the existence of mental disease or deterioration, on the other, bringing to the fore certain abnormal personality types—the shut-in type, the emotional, the egocentric, the inadequate personality, etc. Finally, by means of psychological tests, the intellectual level and certain abilities of each person were ascertained. In this connection, we used the Yerkes-Bridges Point Scale and some Healy supplementary tests. The supplementary tests were not used in every instance, but in all cases the Point Scale was used.

Assembling all of this data together, we arrived at our diagnosis. Very naturally, we found great numbers of cases in which a decision could not be reached; it is not believed that the results in these cases, whatever they may be, would in any great measure influence the generalizations to be drawn from the data we secured.

It may be noted that we called no child feebleminded who tested as less than four years backward mentally. Amongst colored children a greater degree of backwardness was required. Among white adults, we rarely classed as feebleminded any one who tested beyond ten and one-half years. Among the negroes,

owing to the small number of cases studied, we found it very difficult to determine the average adult intelligence; however, in no case did we classify as a mental defective an adult who tested beyond nine years mentally. The great majority of our feebleminded negroes tested eight years and under.

What is Feeblemindedness?

It may be worth while, before entering into the discussion of the data secured in our investigations, to define feeblemindedness and to call attention to some of the now well-known facts about this condition. Feeblemindedness is "a state of mental defect, existing from birth or from an early age, due to incomplete brain development, in consequence of which the person affected is unable to perform his duties as a member of society in the position of life to which he was born."

Feebleminded persons are not merely dull and backward, but are defective in mentality to such a degree that they are incapable, by reason of this mental defect, of receiving proper benefit from the instruction in the ordinary public elementary school. It is clear, then, that this condition is not due to poverty, or to lack of opportunity for training and education; and since it is the result of abnormal brain conditions, once feebleminded, always feebleminded.

Three types of feebleminded persons are recognized—the idiot, the imbecile, and the moron.

The idiot is so deeply defective that his mental development never exceeds that of a normal child of about two years; he does not possess sufficient mentality to avoid ordinary physical dangers.

The imbecile has a higher mental development than the idiot, but his mentality never exceeds that of a normal child of seven years. He is able to avoid ordinary physical dangers, but can never be made self-supporting.

The moron has a higher mental development than that of the imbecile, but his mental level does not exceed that of a normal child of about twelve years. He is able to avoid physical dangers; he is also capable of being made self-supporting; but, owing to his permanently substandard intelligence, he is not able to manage himself and his affairs with ordinary prudence, and does not have sufficient judgment to compete upon equal terms with his fellows.

Feebleminded persons are especially prolific and reproduce their kind with greater frequency than do normal persons, and through

such reproduction provide a legitimate outlet for the exercise of charitable impulses in each generation, and an endless stream of defective progeny, which are a serious drain on the resources of the nation. For this condition is inherited; it is the result, in about 80 per cent of all cases, of defective germ plasm, the expression of defective family stocks, which transmit this condition from generation to generation in accordance with well-known laws of heredity. There is no doubt as to the hereditary potency of this defect in blighting future generations.

Studies of degenerate families in various parts of this country and in certain countries abroad have given startling evidence of the burden feeblemindedness has already become, and the menace it threatens to become, because of its hereditary nature.

In our work here in Georgia, a great number of degenerate families were discovered, but owing to the lack of time and facilities at our disposal, we made little effort to go intensively into this aspect of the problem.

A brief account of some of these families, however, will serve to illustrate the inheritable nature of feeblemindedness, at the same time calling attention to the potency of this defect in causing hereditary pauperism and dependency.

The Relationship of Feeblemindedness to Pauperism and Dependency

Family A

The great-grandmother of this family was a feebleminded woman who died in an almshouse. The grandmother, with sixteen children, a professional beggar, has been dependent upon relief societies and public charities for the last thirteen years; no efforts to make her self-supporting have ever been successful. Ten of these children are known to have been defective, and their families have continuously been dependent upon public funds. One was an epileptic and had an epileptic child. One suffered from tuberculosis. Three were known to be sexually promiscuous and had many illegitimate children. One has recently been in court, charged with attempted murder, for trying to kill her husband with a knife, and is now living openly with another man. In the fourth generation, there are dozens of children, the majority of whom are considered feebleminded by the school authorities of Atlanta.

One, a girl of fourteen, with a mental level of an eight-year-old child, is in the Girls' Reformatory. One, a feebleminded boy, has been in the first grade at school for five years. Another girl has more recently been diagnosed feebleminded and placed in a special class in the public school. Another, a boy, has remained two years in the first grade, and because of his mental deficiency will doubtless never get much further. One, a boy of eight years, has just been before the juvenile court for larceny, and was caught trying to buy ten dollars worth of popcorn. The boy is feebleminded and is urgently in need of proper institutional care and training. Another, a boy, has been in special classes for defective children for the last two years.

Family B

The members of this family live like hermits and avoid social relations with others in the community. The father, who has for years been particularly well known to charitable agencies, is said to have been always peculiar, but in early years he was self-supporting as a peddler. He married a woman of defective mentality, and five children were born, one of whom seems to have been normal. She early left her family and has apparently married well. The other four children are defective mentally. The two oldest boys are now in the reformatory for larceny. The youngest is at home with the father and the girls, one of whom has married a ne'er-do-well who is well known to be a "crook," while the other is a low-grade feebleminded girl with two illegitimate children. They all live together in a little shack of two rooms, and are dependent upon public charity for support.

Family C

The father is a blind beggar of inferior mentality, the mother a feebleminded woman. There are three girls living. The girls, with the father, begged on the streets for a livelihood. All three girls were found to be feebleminded. The oldest is fourteen years old; she went to school from eight to fourteen years, but never got further than the first grade. She has had "spells" since childhood, during which she falls to the ground, bites her tongue, and loses consciousness (epilepsy). During the last year she has begun to hear voices. These voices are very threatening. She is apparently depressed, and remains alone much of the time.

This girl is developing an active mental disorder and is greatly in need of proper hospital treatment.

The next girl, thirteen years of age, went to school from eight to twelve years, but got no further than the first grade. She is said to have had a violent and uncontrollable temper always. She suffers from epileptic seizures. Though she is thirteen years old, she has the mentality of an eight-year-old child.

The youngest girl is nine years old. She has congenital syphilis, and is both physically and mentally dwarfed. She is very selfish and infantile in her behavior, and is considered, at the Girls' Training School where she has been placed, an impossible problem for them to deal with. Though she is actually nine years old, she has not the intelligence of a six-year-old child.

Family D

This is the degenerate family of a seventeen-year-old feebleminded girl who was committed to the Georgia Training School as a wayward child because she was being subjected to immoral and vicious influences. The father, who has been living illicitly with a notorious woman, has a long criminal record, is a syphilitic, and has been charged with keeping a house of ill fame. The mother died of pellagra. Of the seven children, three died in infancy, one of whom was obviously feebleminded. Of the four living children, the oldest sister is a prostitute, one brother a serious alcoholic, and one child has been placed on probation by the court in a good home. The fourth child is the seventeen-year-old feebleminded girl mentioned in this record. When this girl was thirteen years old, she was sexually wayward, and infected with syphilis. Since then her history has been one of sexual promiscuity and petty larceny.

Family E.

This is the family of a sixteen-year-old white feebleminded girl, committed to the state prison for adultery. The father of this girl is undoubtedly a defective and has always been considered by the people in the community "half crazy." He has frequently threatened to kill people, has served a term in the state prison for shooting a man, and has been in court on other charges, such as carrying concealed weapons and the like. He is a drunkard, and frequently moved his family from one shanty to another. The mother was a woman of defective intelligence, a dirty and indifferent housekeeper, with a quarrelsome and ranting disposition.

Eleven children were born to these parents, four of whom died in early infancy. Of the seven living, one is the feebleminded girl referred to above in this report; one, a boy, is a low-grade imbecile; another sister has epileptic attacks. The mental condition of the other four is not known. The feebleminded girl first referred to began a life of immorality at the age of fourteen, had an illegitimate child at the age of fifteen, and since then has been so flagrantly promiscuous that she was committed to the state prison.

It would be possible to go on citing, from the records we have gathered, family after family, illustrating not only the hereditary nature of feeblemindedness, but likewise the important causal relationship it bears to pauperism and dependency in general.

It is already clear to us that vast sums of money are being spent by the charitably inclined people of Georgia in giving relief to unimprovable cases. Our investigations have shown that feebleminded families are allowed to live in the community and propagate their kind, nurtured and cared for by philanthropic efforts and thus encouraged to leave behind them a large progeny of feebleminded; which in turn, protected from infant mortality and carefully nurtured and helped by the good people of the community, reproduce their kind out of all proportion to the normal members. And so goes on the stupid work of preserving and increasing our socially unfit strains through succeeding generations.

We have run across certain pauper feebleminded families in Georgia that have been supported by churches and organized charities for four and five generations. And this is not all, for within certain almshouses are to be found feebleminded persons whom society has allowed to propagate to such an extent that one almost feels it would be better to turn these places into lying-in hospitals.

Lula H., who has for years been an inmate of a certain almshouse, well illustrates this point; her five children are cared for by the good people of the state in a certain orphanage. In our own investigations, the entire almshouse situation of Georgia was not studied, owing to lack of time, but of those investigated, 40 per cent of the inmates were feebleminded persons—persons who are now most helpless and who throughout life have never been self-supporting, but a continuous burden to the community in which they lived. Would it not have been good economy to have prevented this human waste—to have trained these persons to be

self-supporting, in cases where this was possible, and at least to have cut short the propagation of their defective strains?

There is another phase of this problem that is worth while discussing here and that is the relationship of feeblemindedness to dependency as seen in connection with orphanages. There are approximately 2,825 children in orphanages and church homes throughout Georgia. Inasmuch as all of the children in these institutions will at a certain period be released into the community and be expected to assume their proper relationship to society, it is a matter of great importance to know what percentage, if any, of these children are feebleminded and thus a potential burden and menace to the community that is to receive them.

In order to get some idea of the problem, a typical orphanage was selected, and all of the children in this institution were examined mentally. There were 101 children, varying in ages from five years up to eighteen years.

TABLE I

Showing the relationship of the actual age of children in a certain orphanage to their mental age

Actual Age	*Mental Age*													
Years	4	5	6	7	8	9	10	11	12	13	14	15	16	17
5	3													
6	6	1	1											
7	1	1			2									
8		2	1	2		1								
9			6		7									
10			1	2	4	1	2							
11				2	4	2								
12			1		3	5	1	3	1					
13					1	4	1	2						
14			1			4	3	1						
15							1	6			1	4	1	
16				1	1								3	1
17							1	1						1

It will be seen from the above table that 13.8 per cent of these children were retarded one year mentally; 15.8 per cent were

retarded two years mentally; 14.8 per cent were retarded three years mentally; 16.8 per cent, four years mentally; 6.9 per cent, five years mentally; one case was retarded six years; one case seven years; two cases eight years; and one case nine years. Finally three cases were mentally advanced one year. The details of this examination are shown in Table II.

TABLE II

Showing mental diagnoses of the inmates of a certain typical orphanage

Normal	22.9%
Dull normal	9.9%
Subnormal	34.8%
Feebleminded	28.7%
Psychopathic personality	1.9%
Mentally diseased	.9%
Epileptic	.9%
Total	100%

It will be seen from the above table that 32.4 per cent, practically one out of every three children, are suffering from some serious abnormal mental condition, are mentally defective or mentally ill. Each one of these children is in need of much more specialized training than these institutions are equipped to give him, and this not as a sentimental consideration, but as a sensible measure against future dependency, crime, prostitution, vagrancy, and the like.

Twenty-eight and seven-tenths per cent of these children are feebleminded, and if these figures hold good in other orphanages throughout the state—and there is no reason, so far as we see, why they should not, for the figures themselves are conservative as compared with those coming from many other states—then there are approximately 810 feebleminded children in orphanages and church homes in Georgia. All of these children will be released into the community at that period of life when they are least fitted to meet its obligations, a period when even the most normal children, with good judgment and reasoning powers, good self-control and mental balance, are often subjected to such stresses of temptations as to develop criminal careers.

RELATIONSHIP OF FEEBLEMINDEDNESS TO ADULT CRIME, VAGRANCY, ETC.

Another aspect of the burden which the adult feebleminded impose on society is seen in their failure to measure up to the

social and moral mandates of the communities in which they live.

The depredations growing out of their criminal behavior furnish one of the most satisfactory arguments for a state-wide policy of protection against the menace of feeblemindedness. We expected to find, from a study of the inmates of the Georgia State Prison and the inmates of several representative jails, a fairly good picture of the relationship of feeblemindedness to adult crime in this state.

Georgia State Prison

Examinations of all of the inmates of the state prison were made.

There were 216 men in the men's prison, and 126 women in the women's prison. In the state of Georgia, the able-bodied male prisoners committed to the state penitentiary are worked in the so-called "chain gangs," on roads throughout the state. Men suffering from physical diseases, or any serious physical or mental infirmity, are transferred to the state-prison farm. It would be expected, then, that the male inmates of the state prison, being a rather highly selected group, would show a much larger percentage of mental abnormalities, particularly of mental disease, than is to be found in the average state prison. Let it not be understood from this that there is any careful selection, based upon mental and physical examinations, of those who should go to the state-prison farm rather than to the chain gangs.

Of the 216 men examined at the state-prison farm, 111 were white and 105 negroes. They averaged in age from fifteen to eighty.

We rated these individuals according to their physical health, in the following manner: those rated Good showed no evidence, in a cursory examination and in the history given by the prison physician, of any condition of sufficient importance to impair their general health; those rated Fair showed evidence of slight temporary disturbances of health from minor ailments; those rated Poor were suffering from actual physical diseases that definitely impaired their general health; those rated Bad were urgently in need of hospital care and treatment.

A great many of the individuals at this institution (the exact number was not ascertained) were suffering from syphilis and either had been in the past or were at the time of examination under treatment. Sixty per cent of the inmates were in good or fair physical health; 40 per cent were in poor or bad physical

health. Five of the cases seen were blind, and eighteen were crippled. The following table shows the offences for which these persons were committed.

TABLE III

Showing offences of inmates at Georgia State-Prison Farm

Burglary	Larceny	Murder	Manslaughter	Assault and battery	Rape	Vagrancy	Selling whisky	Attempt at murder	Robbery	Forgery	Bastardy	Carrying revolver	Embezzlement
30	32	63	21	3	9	7	8	12	5	7	1	2	4

Wrecking freight train	Shooting cows	Kidnaping	Mayhem	Other Misdemeanors	Seduction	Bigamy	Moonshining
1	1	1	1	3	1	1	3

Forty-two and two-tenths per cent of these individuals voluntarily admitted that they had served previous commitments, were chronic repeaters, the majority having spent years in and out of prisons.

The following table shows the mental level of these prisoners. It should be borne in mind that, with few exceptions, practically all of these individuals were adults, ranging in age from fifteen years to eighty years.

TABLE IV

Showing mental level of 216 men at Georgia State-Prison Farm

Mental Age	*White*	*Negro*
5		4
6	7	5
7	3	4
8	5	24
9	11	18
10	13	18
11	17	26
12	2	—
13	3	1
14	2	—
15	3	2
16	10	3
17	5	—
18	30	—
Total	111	105

Seventy-two and one-half per cent of these individuals had the mental level of the average American child of twelve years or under. Ninety-four per cent of the negroes had the mental level of twelve years or under, while 52 per cent of the whites averaged twelve years or under.

The following table shows the mental diagnoses of these individuals:

TABLE V

Diagnosis	*White*	*Negro*	*Total*
Normal	30	28	58
Dull normal	11	5	16
Subnormal	20	23	43
Feebleminded	17	21	38
Epileptic	5	7	12
Psychopathic	9	3	12
Mental disease or deterioration	12	17	29
Pellagra	3	1	4
Paranoid condition	4	—	4

Sixty-five and eight-tenths per cent of these persons are classifiable as mentally abnormal types—are so handicapped by mental defect or mental disease that the method of treatment they are now receiving will do little in the way of equipping them to live more normal lives when the period of their sentence has been served. Seventeen and five-tenths per cent of the inmates should not be returned to the community at the expiration of their sentence, but should be segregated because of their feeblemindedness.

All women offenders committed to the state penitentiary are confined at the women's branch of the state-prison farm. There were, at the time of our investigations, 126 women so confined—24 white women and 102 negro women. The ages of these women varied from fifteen years up to sixty. Sixty-three per cent, almost two-thirds, were under thirty years of age.

The following table shows the offences for which they were committed:

TABLE VI

Showing offences of the women inmates of the Georgia State-Prison Farm

Larceny	Burglary	Manslaughter	Running away from home	Murder	Accessory to murder	Selling whisky	Vagrancy	Attempt at murder	Highway robbery	Forgery	Immorality	Writing insulting letters	Arson	Drug user	House of illfame	Mayhem
28	4	17	1	41	2	1	6	3	3	1	7	1	2	2	1	1

Twenty-three and eight-tenths per cent of these persons had served previous commitments. The small number of repeaters among the women, as compared with the male inmates of the state prison, is noteworthy, but it should be borne in mind that a very large portion of the women who are in this institution are here for serious crimes, many of which were first offences. For instance 50 per cent of these women, or every other woman, was committed either for murder, manslaughter, or attempt at murder.

TABLE VII

Showing the mental level of the women inmates at the Georgia State-Prison Farm

Mental Age	*White*	*Negro*	*Total*
5	2	4	6
6	1	4	5
7	2	8	10
8	3	31	34
9	4	25	29
10	2	13	15
11	5	11	16
12	—	1	1
13	3	2	5
14	—	—	—
15	—	—	—
16	2	3	5

Seventy-eight per cent of these women had the mental level of the average American child of twelve years, or under. The following table shows the mental diagnoses of these women offenders.

TABLE VIII

Diagnosis	*White*	*Negro*	*Total*
Normal	3	25	28
Dull normal	—	2	2
Subnormal	2	20	22
Feebleminded	12	42	54
Mental disease or deterioration	1	4	5
Psychopathic	4	—	4
Epileptic	2	9	11

Seventy-six per cent of these women are classifiable as subnormal, defective, or mentally diseased persons. Forty-two and eight-tenths per cent of them are feebleminded.

County Jails

We felt that an examination of a sufficient number of the inmates of the county jails would give us an insight into another most important aspect of the relationship between feebleminded-

ness and adult crime. For this purpose two representative jails were chosen, one in southern Georgia and one in northern Georgia. One hundred cases were studied, this being an unselected group made up of all the inmates of the southern county jail and the "run of the mine" in the northern county jail.

Sixty per cent of the inmates of these two jails were under thirty years of age. Thirty-six per cent were white and 64 per cent negroes. Sixty-six per cent were men, and 34 per cent women. The offences for which they were arrested are shown in the following table.

TABLE IX

Showing the offences of 100 inmates of certain county jails in Georgia

	Larceny	Burglary	Murder	Manslaughter	Assault and battery	Rape	Vagrancy	Selling whisky	Attempt at murder	Robbery	Idle and disorderly	Carrying revolver
No.	24	2	7	1	5	2	4	6	5	1	4	2
Per cent	24	2	7	1	5	2	4	6	5	1	4	2

	Bigamy	Other misdemeanors	Possession of whisky	Accessory to murder	Forgery	Possession of stolen goods	Moonshining	Drunk	Failure to register	Drugs	Witness	Bail of trover
No.	1	1	5	1	4	2	15	1	1	3	2	1
Per cent	1	1	5	1	4	2	15	1	1	3	2	1

Fifty per cent of these individuals never got further than the fourth grade in school. Seventy-seven per cent tested, by the Yerkes-Bridges Point Scale, twelve years or under mentally. Sixty per cent had the mental level of the average American child of ten years or under.

The following table shows the mental level of these individuals according to race:

TABLE X

Showing mental level of jail inmates according to race

Mental Level Years	*White* per cent	*Negro* per cent	*Total* per cent
5	—	2	2
6	—	2	2
7	—	3	3
8	3	16	19
9	3	19	22
10	5	5	10
11	7	10	17
12	—	—	—
13	4	—	4
14	1	—	1
15	1	1	2
16	12	4	16
Unknown	—	2	2
Total	36	64	100

From the above table it is seen that 30 per cent of the white inmates have a mental level of ten years or under, while 73 per cent of the negroes have a mental level of ten years or under.

TABLE XI

Showing mental diagnoses of 100 inmates of certain county jails in Georgia

Diagnosis	*White* per cent	*Negro* per cent	*Total* per cent
Normal	12	14	26
Dull normal	1	2	3
Subnormal	10	13	23
Feebleminded	8	26	34
Epileptic	1	4	5
Psychopathic	2	1	3
Mental disease	—	2	2
Drug deterioration	1	—	1
Paranoid	—	1	1
Pellagra	1	—	1
Unclassified	—	1	1
Total	36	64	100

Seventy per cent of the inmates of these jails either are subnormal mentally or are handicapped by such serious pathological mental conditions as feeblemindedness, epilepsy, mental disease or deterioration, etc. Thirty-four per cent are feebleminded persons, with a mental level of ten years or under.

THE RELATIONSHIP OF FEEBLEMINDEDNESS TO PROSTITUTION AND THE SPREAD OF VENEREAL DISEASE

Syphilis and gonorrhea form a combination possibly as produc-

tive of evil as any scourge that has ever afflicted mankind. These two conditions are striking at the very source of life and deteriorating the human race.

The high percentage of miscarriages associated with syphilis, the fact that this disease ranks first in its ability to cause destructive diseases of the nervous system, the fact that in its wake follow idiocy, epilepsy, feeblemindedness, insanity, locomotor ataxia, etc., make the proper handling of this condition a matter of the gravest importance to the general public.

The seriousness of gonorrhea, especially to women, and the growing army infected, is a source of much alarm to serious-minded students of the subject.

Few diseases that afflict women are fraught with more permanent harm. In some, it produces only the very mildest symptoms; in others, the fulminating signs are present—acute inflammation of the tubes and ovaries, abscesses, and peritonitis. Between these lie all degrees of pelvic ills, acute and chronic. This disease is a large and important factor in the causation of blindness and many other serious conditions.

In short, we have in syphilis and gonorrhea diseases of such grave significance to society in general and the individual in particular that their existence with such widespread frequency amongst all immoral women imposes a serious duty upon our health authorities.

The one outstanding and most important factor that complicates any and every program for the prevention of venereal disease is the high frequency of feeblemindedness amongst those who are considered most responsible for its spread.

The frequency of this condition is well attested by reports coming from all parts of the country. Of 639 prostitutes studied in the Chicago Morals Court, 62 per cent were considered mentally defective.

Of 243 women studied at the Massachusetts Reformatory for Women, which group included all the women in the institution in whose histories there had been at any time commercialized promiscuous sex immorality, 49 per cent were found defective mentally.

Of 300 prostitutes examined by the Massachusetts Vice Commission, of which Dr. Walter E. Fernald was chairman, the mental defects of 51 per cent were so pronounced as to warrant their legal commitment to an institution for the feebleminded. The Com-

mission states in its report that the women in this group came from shiftless, immoral, and degenerate families; they were industrially inefficient, as shown by the low wages received and by their inability to retain a position, even in unskilled callings; they were very deficient in judgment and good sense; they lacked ordinary general knowledge and practical information.

Two hundred and eighty-nine prostitutes studied by the Baltimore Vice Commission showed 63.7 per cent to be syphilitic.

Twenty-three per cent of the inmates of a large reformatory who were found to be in need of custodial care because of feeblemindedness showed 90 per cent of gonorrhea and 60 per cent of syphilis.

In connection with our survey here in Georgia, we desired very much to secure a study of this problem that might localize interest in the highly important relationship which feeblemindedness bears to the whole question of prostitution and the spread of venereal disease, a question now so prominently before the public because of the praiseworthy campaign being waged by our health authorities.

We were able to secure the mental examination of 122 immoral women and girls. About one-half of these were examined at the Atlanta stockade; the others were court cases, Girls' Training School cases, and individuals confined in jails. They ranged in age from fourteen to thirty-five, and were all guilty of sexual promiscuity. The following table shows the mental diagnoses of these 122 cases:

TABLE XII

Showing mental diagnoses of 122 immoral women

Normal	25.4%
Subnormal	20.5%
Feebleminded	43.5%
Psychopathic	8.2%
Epileptic	1.6%
Mentally diseased	.8%

Fifty-four and one-tenth per cent of these individuals are suffering from serious mental abnormalities, feeblemindedness being the most common condition—43.5 per cent.

It is obvious that these girls are unfitted to compete on equal

terms with their normal fellows. Their life histories show evidences of marked economic instability; they have drifted from pillar to post, unable, because of their incompetence, to hold positions sufficiently long to enable them to become self-supporting. The life of prostitution is a simpler and more natural one for them. They are at the lowest ebb of the industrial market, the last hired and the first fired.

With the zeal of the reformer, we herd these feebleminded girls into our venereal clinics and hospitals and, at considerable cost in time and money, we seek to cure them of venereal disease and promptly turn them out into the community to acquire it over again. Are we not acting stupidly in returning to the community girls whose future immoral conduct we can predict with as much certainty as we can that on a hot summer day most of the people will be found on the shady side of the street?

An institution for defective delinquent girls will be a charter of liberty for this most helpless, unfortunate, and potentially dangerous class, taking them from the streets and highways, where they have been the defenceless prey of lust and greed, and placing them in an environment suited to their own particular needs, where they may be made happy and useful; where they may be trained along industrial lines to that degree of industrial efficiency that will enable them in a great measure to support themselves.

Finally, not the least important of all these benefits is the protection such an institution will afford society.

Relation of Feeblemindedness to Juvenile Vice and Delinquency

Observers everywhere are united in stating that the sources of criminality lie in conditions of childhood and adolescence. The majority of criminals begin their careers in late childhood. It is this well-recognized fact that has convinced all serious-minded students of this problem that the prevention of crime finds its solution in the proper handling of the juvenile delinquent.

It is not our purpose here to discuss the entire question of juvenile delinquence. This will be taken up in a later special report on the defective delinquent. In this connection, we wish merely to call attention to the very definite relationship existing between mental defect and juvenile vice and delinquency. For purposes

of this study, all of the inmates of the Girls' Industrial Training School, the State Reformatory for Boys, the Fulton County Reformatory for Boys, and a sufficiently large group of children from the "run of the mine" in the Juvenile Court of Atlanta were chosen for examination.

Juvenile Court

A careful mental examination of each child coming before the court was made. It was thought that one hundred records would give us sufficient data to permit of fairly safe generalizations as to what percentage of children coming before the court were feebleminded. Of the children studied, thirty-one were negroes and sixty-nine were white children. They averaged in age from five years up to seventeen. The following table gives an idea of their offences, or the reasons for their being brought before the court:

TABLE XIII

	Incorrigibility	Disturbing the peace	Associating with immoral person	Robbery	Burglary	Larceny	Running away from home	Truancy	Improper or incomplete guardianship	Vagrancy	Shooting	Cursing and fighting
No.	8	1	2	1	5	34	18	1	23	4	1	2
Per cent	8	1	2	1	5	34	18	1	23	4	1	2

It is of interest to note that 23 per cent—almost one out of every four children—had been in court before, some a great number of times. Many have been arraigned four, five, and six times. We see here the beginnings of recidivism, which shows itself later on in confirmed criminality. As said before, we will not enter here into a discussion of the home conditions, developmental factors, both physical and mental, that act as important causes underlying the behavior of these juvenile delinquents; nor will we go into questions of employment, personality traits, and mental characteristics, all of which, however, are essential in considering the problem of delinquency.

TABLE XIV

Showing the relationship of actual age to mental age

Actual Age	*Mental Age*														
Years	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
5	1														
6					1										
7	1					3									
8		1	1		1	2		1							
9						1	3								
10				1	3	1	1								
11			1	2	1	3			2		1				
12					1	3	3		1		1	1		3	
13							1	6			3				1
14					1	3	3	5	5		1	2	1	4	
15						1	1	1	4	1		1	2	3	4
16															
17										1	1				

It will be seen from the above table that 15 per cent of these children test at age; that 24 per cent test above age, are supernormal; and that 61 per cent test below age. Seven per cent are retarded one year; 1 per cent are retarded two years; 22 per cent, three years; 17 per cent, four years; 7 per cent, five years; 5 per cent, six years; and 2 per cent, seven years.

In short, 14 per cent of these children were retarded five or more years mentally. These fourteen cases—together with three children who were retarded four years mentally, but whose past history gave marked evidence of feeblemindedness—constituted our seventeen feebleminded children.

The following table will show the mental diagnoses of these one hundred cases, as arrived at by carefully gathered social histories and psychiatric and psychological examinations. It will give also some idea of mental conditions as they are found amongst the two races.

TABLE XV.

Showing mental diagnoses of 100 juvenile-court cases as related to race

Diagnosis	*White*	*Negro*	*Total*
Normal	24	12	36%
Dull normal	4	2	6%
Subnormal	17	13	30%
Feebleminded	13	4	17%
Psychopathic	8	—	8%
Epileptic	3	—	3%

Fifty-eight per cent of these children—every other child—is handicapped by some form of mental defect or abnormality; 17 per cent are feebleminded.

Simply trying out these children again and again on probation, the use of judicial reprimand, or sentencing them for short terms, will never solve the problem or prevent the careers that these mental unfortunates give promise of developing.

Fulton County Reformatory for Boys

This institution is supplied by the juvenile court of Atlanta. It contained, at the time of investigation, 113 boys, all white, varying in age from nine years to seventeen, committed for the following offences:

TABLE XVI

Showing offences of inmates of Fulton County Reformatory

Larceny	Burglary	Shooting another	Running away from home	Idle and disorderly	Robbery	Forgery	Incorrigible	Vagrancy	Assault and battery	Sex offence
55	19	1	9	4	3	4	13	3	1	1

Thirty-seven and two-tenths per cent of these persons were first offenders, while 62.8 per cent—almost two out of every three boys—had had previous commitments. Forty and seven-tenths per cent of the total number of inmates had each several arrests to his credit—were recidivists, chronic repeaters.

It is a matter of no small concern to note the striking evidence of failure of society, the court, and the institution to check the progress of these delinquent careers.

The two following tables will throw much light on the reasons

for this failure, and will point toward the proper method of treatment of these cases.

TABLE XVII

Showing the relationship of the actual age to the mental age

Actual Age	*Mental Age*											
Years	7	8	9	10	11	12	13	14	15	16	17	18
9	1											
10		4			2							
11	1	2	1		1							
12		1	2	4	1		3			2	1	
13			3	1	4		2	1	1	2		
14		1		3	6		2	1	1	4	2	5
15		1	3	1	6		2	1	2	2	3	4
16		2			4		2			6	1	3
17					1		1					3

From the above table, it will be seen that 14 cases are at age, 38 cases are above age mentally, and 61 cases—approximately 54 per cent—are mentally below their normal age.

TABLE XVIII

Showing mental diagnoses of 113 inmates of Fulton County Reformatory for Boys

Normal	49
Dull normal	5
Subnormal	38
Feebleminded	17
Epileptic	2
Psychopathic	2

From the above table, it is seen that 52.2 per cent of the boys in this institution are classifiable in terms of deviation from normal mental health, while 15 per cent of the inmates are feebleminded. Every other boy is certainly in need of more individualized treatment and training than this institution is at present equipped to give him.

State Reformatory for Boys

This institution is located at Milledgeville, Georgia, near the state prison.

At the time at which this investigation was made, there were 112 boys in this institution, varying in age from nine years to twenty. Fifty-two were white boys and sixty were negroes. The races are separated, there being one building for the white and another for negro boys.

The following table shows the offences for which these boys were committed to the reformatory.

TABLE XIX

Showing the offences of 112 inmates of the State Reformatory

Larceny	Burglary	Shooting at another	Incorrigible	Carrying revolver	Arson	Robbery	Running away from home	Assault and battery	Other misdemeanors	Vagrancy	Forgery	Manslaughter
62	19	3	4	1	2	1	3	1	8	4	2	2

Forty-three and seven-tenths per cent of these individuals had had previous commitments. Almost every other boy had shown evidence—not only in the conduct that resulted in his present arrest, but in delinquent behavior for a period of years—of such persistent antisocial tendencies as to constitute a clear deviation from average normal conduct. Approximately 74 per cent were never able to get farther than the fourth grade in school.

About 80 per cent were retarded from one to eight years in their mental development. Eleven were retarded one year; eight, two years; thirteen, three years; twelve, four years; sixteen, five years; eleven, six years; fourteen, seven years; and five, eight years. The following table shows the mental diagnoses of these cases:

TABLE XX

Normal	35
Subnormal	36
Borderline mental defect	7
Feebleminded	27
Epileptic	4
Psychopathic	3
	112

Sixty-eight and seven-tenths per cent were suffering from nervous or mental abnormalities. Twenty-four and one-tenth per cent—one out of every four cases—were feeble-minded.

Georgia Training School for Girls

We were exceptionally fortunate at this institution as, through the hearty coöperation of the superintendent and the help of two very capable workers from the Children's Bureau at Washington, we were able to secure some instructive case histories of delinquent and defective girls. The use of several of these cases in connection with this part of the report would, we believe, be both interesting and profitable, but owing to lack of space, it will be necessary to limit these illustrations to two or three cases, the histories of which will follow the general discussion of the findings at this institution.

One hundred girls were examined at this training school, which included practically all the inmates of the institution, with the exception of five or six girls who were received during the time that this investigation was being made. They were all white girls, averaging in age from nine years up to nineteen. The following table shows the offences for which they were sent to the institution:

TABLE XXI

	Improper guardianship	Incorrigible	Immorality	Associating with vicious and immoral persons	Larceny	Vagrancy	Burglary	Arson	Other delinquencies	Dependent
No.	5	36	19	23	7	5	1	1	2	1
Per cent	5	36	19	23	7	5	1	1	2	1

Fifty-one per cent of these girls had never got further than the fourth grade in school; 70 per cent were retarded one or more years; 49 per cent were retarded four or more years; 12 per cent were advanced one year; 2 per cent were advanced two years; 2 per cent were advanced three years; and one was advanced five years mentally.

TABLE XXII

Showing the diagnoses of 100 girls at the Georgia Training School

Normal	31	31%
Subnormal	23	23%
Feebleminded	27	27%
Epileptic	3	3%
Psychopathic	14	14%
Mentally diseased	2	2%
	100	100%

Sixty-nine per cent of the inmates of this institution are not to be considered normal girls—are classifiable in terms of deviation from average normal mental health.

Twenty-seven per cent of them are feebleminded and will never be able to take their place in society and compete with their normal fellows. Nevertheless, at the age of twenty-one they will be returned to the community. Though adult in years and fully grown in their physical development, they will still remain mental children with the intellectual level of eight, nine, and ten years, and with just the same degree of self-control, moral judgment, planning ability, and discrimination.

Summary of Juvenile Delinquency

Is it not clear from the above tables that in our institutions for delinquent children we are dealing with a strikingly large number of repeated offenders, of recidivists, in whom we have failed to accomplish that which we set out to accomplish?

At least 50 per cent of these delinquent children are repeated offenders, but behind this there are facts in their careers that should have called our attention to them at a much earlier period. At least 60 per cent never got further than the fourth grade in school. Correlated with this are the striking facts that 66 per cent of these children are retarded one or more years in their mental development; that at least 60 per cent should be dealt with by entirely different methods from those that are suitable in the case of normal-minded children; while 22 per cent are undoubtedly feebleminded and in need of special institutional care, adapted to their particular mental weakness.

Illustrative Cases

A feebleminded negro boy of fourteen years, with the mind of a seven-year-old child, is serving a reformatory sentence for attempting to rape a twelve-year-old white girl.

Two low-grade feebleminded negro girls, with the mental levels of seven and eight years, have been committed for life to the state prison for two murders.

A fifteen-year-old feebleminded boy, committed to the state reformatory for vagrancy, has been a repeated offender, having been in court several times before for larceny and the like. The boy's great-grandmother was apparently a very nervous, unstable, and poorly balanced woman. The boy's grandfather was considered a "bad character"—had a criminal record, was alcoholic and immoral. The boy's mother had a violent temper, was very emotional, had a habit of running into the streets and screaming when angered. One sister had a very violent temper and would tear her clothes to pieces. The mother married three times; by the first husband, she had five children, all of whom had criminal records and were sent to institutions. One girl, while an inmate of one of these institutions, whipped the matron and had to be transferred where more severe disciplinary measures could be secured. After her release, she married, but very soon separated from her husband and deserted her three little children. Another sister was a prostitute and ran a road house. She married a man who committed a murder. And so the story of delinquency, prostitution, crime, etc., runs through the entire family.

The subject of our story, one of the sons, very early in life proved impossible to control. He was described as indolent, dishonest, untruthful, stubborn, and "has no morals"; he was placed out by different agencies in various families, but either ran away or had to be taken away because the families would not tolerate him. Twice he escaped from the detention house while his trial was pending. Finally he landed in the state reformatory. Though this boy is fifteen years old, he has the mind of a little child and will always remain a mental dwarf. He promises a very dangerous career, and nothing could possibly be more stupid than the present policy of locking this feebleminded boy up for a short term of confinement and then turning him out again no better fitted for life than he was the day he entered prison.

The Relationship of Feeblemindedness to the Public Schools

There is possibly no other question so vital to the good of our elementary public schools as that of what shall be done with mentally defective children. They form from 2 to 4 per cent of the population of these schools.

All educational authorities agree that they are unable to profit by the ordinary methods of public-school instruction. They are a burden to the teacher and a constant menace and hindrance to the other children in the classes. Their stupidity makes them the dunces of the schools, and their simplemindedness renders them the constant butt of jokes and the perennial source of childish ridicule.

But this is not all. These defective children later on become a burden and a danger to the community in which they live, in that they become recruits to the vast army of prostitutes, criminals, paupers, vagrants, and the like that fill our courts, jails, prisons, almhouses and provide the unimprovable cases for organized charity.

The foregoing tables show the penalty we are paying in dollars and cents and wasted human lives for our neglect to provide for the care and training of these feebleminded persons at a time when prevention of much of their antisocial conduct, dependency, and degradation would have been possible. In our present investigation we set about to determine what proportion of the school children of Georgia were mentally defective and thus in need of more specialized care and training than they are at present receiving in the public schools. In this we were very ably assisted by the State Department of Education.

A survey was made of typical schools, chosen by Mr. M. L. Duggan, the representative of the State Department of Education, in three different sections of the state—the mountainous section, the mill and rural section of north-central Georgia, and a large urban community in southern Georgia. It was our aim to divide these three sections equally and study about the same number of children in each section of the state. In every instance where a school was selected, an examination of every child in the various grades was made. In this way we secured examinations of 915 white school children and 120 negro children. The following table gives some idea of the actual age of these

children and the amount of mental retardation there is present:

TABLE XXIII

Showing the relationship of the actual age of these children to their mental age

Actual Age	*Mental Age*														
Years	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
5		1	1	2	1										
6	1	5	7	9	10	6	2								
7		1	1	10	20	27	5	3	3						
8		1	2	4	12	36	18	23	7		2				
9		2	2	2	7	30	22	27	17	3		1		1	
10				1	2	15	31	26	31	7	4	1	1	10	
11						15	22	20	33	4	10	13	3	11	
12						7	10	12	32	17	2	4	2	16	
13						4	10	7	19	7	24	4	1	11	
14						1	8	5	11	3	10	10	5	23	
15							1	3	9	2	1		3	9	
16		1					2	2	3	1	3	1	1	7	
17									1	2	2	1		1	

Three hundred and forty-five cases, or 37.7 per cent, were retarded from one to six years mentally; 166 were retarded one year; 86 were retarded two years; 58 were retarded three years; 26 were retarded four years; 6, five years; 3, six years. Thirty-five, or 3.6 per cent of the cases, were retarded four years or more mentally.

Two hundred and sixty-seven, or 29 per cent, were advanced from one to seven years mentally. One hundred and five were advanced one year; 65 were advanced two years; 41, three years; 21, four years; 17, five years; 15, six years; and 3, seven years.

There could be no greater fallacy than to assume that all children react alike to the same standards of public-school training. We will hardly have the space to enter into a discussion of the energy, time, attention, and patience that the children who are retarded mentally exact of the grade teacher, to say nothing of

the harm they are doing to the more normal children in taking time and mental energy that could be much more profitably devoted to those capable of proper progress. The expense of the mentally retarded is seen in their repeating of grades.

The following table speaks for itself. It was impossible to secure from the teachers in all the schools visited an idea of the number of children who were repeating grades, this because of the frequent change in teachers. Schools were found that had two or three teachers in one year. The following school was selected because it contained exact data on every child that repeated grades. There were 185 children in this school.

TABLE XXIV

Showing number of children who repeated grades in a certain county school

Grade	*Repeating grade once*	*Repeating grade twice*	*Repeating grade three times*
1st	35	1	3
2nd	32		
3rd	28		
4th	9		
5th	12	1	
6th	2	1	
Totals	118	3	3

There were 118 repeaters in this school. Three and two-tenths per cent of these children had repeated grades more than once.

In every classroom throughout the state are to be found pupils who are not able to keep step with the rank and file of children. Some of these are backward because of prolonged absence from school, serious illness, physical defects, lack of interest, etc., and are in need of specialized treatment and training. But after these are eliminated, there still remain a few children who perplex both principal and teachers; who, no matter what individualized care and treatment they may receive, fail to progress properly. They show an incapacity for profiting by ordinary school instruction and can never keep up with the grade work, because they are mentally defective. They are a serious misfit in the schools, and they greatly hinder the proper training of normal children.

The following table gives some idea of the size of this group in the schools visited by us throughout the state:

TABLE XXV

Showing the mental diagnoses of 915 white school children

Supernormal	87
Normal	468
Dull normal	131
Subnormal	177
Feebleminded	32
Epileptic	2
Psychopathic	18
Total	915

Three and four-tenths per cent of the children studied were mentally defective.

The full significance of these figures is not to be seen only in the failure of these children to measure up to the ordinary public-school instruction, but in the promise they give of future social difficulties, of industrial inefficiency, of economic instability, of prostitution, crime, vagrancy, and the like.

These defectives will always be mental children, and upon reaching the chronological age of twenty-one, they will, without the proper sort of training, be little better able to measure up to the moral and social mandates of the community in which they live than they are to-day as children in the public schools; and this not because of any innate wickedness or viciousness on their part, but simply because of the fact that a person whose intelligence develops only to the degree attained by the average child of eight or ten years is always a misfit in a form of society which has been arranged for people whose minds continue to develop until the changes of old age begin.

We did not have sufficient data to make generalizations concerning the negro school child. With the time at our disposal, it was possible to secure the examination of the children in only one school. This was in a colored school in southern Georgia. This school contained 120 children. The superintendent stated that practically all of the other schools in the county were closed. One colored school that was visited contained only six pupils. The following table is offered for whatever it may be worth. We attempt to make no generalizations.

TABLE XXVI

Showing mental diagnoses of 120 negro school children

Normal	27
Subnormal	80
Feebleminded	13
Epileptic	0
Psychopathic	0

It was found that 22 of the children were retarded one year mentally; 26, two years mentally; 25, three years mentally; 17, four years mentally; 12, five years mentally; 5, six years mentally; 12, seven years mentally; one was advanced one year. As said before, we do not propose to draw any conclusions bearing upon the negro school children of Georgia from this table.

Summary

The results of the survey may be briefly summarized as follows:

Forty per cent of the inmates of the almshouses investigated were feebleminded, and feebleminded families were found in the state that have been supported by church and organized charities for four or five generations.

A study of a typical orphanage showed that 28.7 per cent of the children were feebleminded. If the same percentage exists in the other orphanages of the state, then there are at least 810 feebleminded children in orphanages who need special care and training in a school for the feebleminded.

Seventeen and five-tenths per cent of the male inmates of the state-prison farm were feebleminded. The striking fact at this institution was not so much the presence of feeblemindedness, which we had expected to find in a larger proportion of the inmates than was the case, but the great number of other forms of mental abnormality, mental disease and deterioration, epilepsy, and the like. Undoubtedly the able-bodied mental defectives are placed out in the chain gangs. Sixty-five and eight-tenths per cent of the inmates of this institution are classifiable in terms of deviation from normal mental health. Of the women inmates of the prison, 42.8 per cent were found to be feebleminded. In the two typical county jails examined, 34 per cent of the inmates were feebleminded, with a mental level of ten years or under.

Of 122 immoral women examined, 43.5 per cent were found to be feebleminded. The present policy of treating these feebleminded girls for venereal disease and then turning them out into the community to acquire it over again is a costly one. Probably the greatest single factor in the spread of venereal disease is the feebleminded prostitute. An institution for defective and delinquent girls and women is most urgently needed.

Of 100 cases of juvenile delinquents studied in the juvenile court, 17 per cent were found feebleminded. Fifteen per cent of the Fulton County Reformatory for boys were feebleminded,

24.1 per cent of the inmates of the State Reformatory for Boys, and 27 per cent of the inmates of the Georgia Training School for Girls. It is these feebleminded delinquent children that later on become the chronic recidivists, as is seen in our jails, adult criminal courts, and state prisons.

Finally, 3.5 per cent of the children examined in the public schools were found to be feebleminded. These are the children who are to become the "grist" of our future courts, jails, reformatories, and state prisons, and to form the very backbone of the vast and grim procession of paupers, criminals, and prostitutes of to-morrow.

Conclusions

Would not the experience of the United States Army in the present war prove valuable to every state in the Union?

At the beginning of the war, the War Department requested the authorities at the Fort Leavenworth Disciplinary Barracks to estimate the increase in delinquency to be expected with the drafting of an army of three million men. This estimate was to be based upon the experience of the Civil and Spanish Wars and the Mexican Border trouble. The official estimate was that it would be necessary to provide for 50,000 delinquents. As a matter of fact, 5,000 was the highest mark ever reached—one-tenth of the expected increase. It may be remarked that every soldier, on his entrance into the army, was given a mental examination, and thus the mentally abnormal and unfit were rejected. Correlated with this, we find a striking decrease in delinquency—one-tenth of the expected increase.

Furthermore, in civil life, it is found that at least 50 per cent of the inmates of the state prisons throughout the country are suffering from abnormal nervous and mental conditions. Now, with the elimination of the most serious cases as unfit for army life, it was found that only 10 per cent of the 5,000 delinquents suffered from any abnormal nervous or mental condition.

Is there not a lesson here for us in the handling of our serious antisocial problems? Would not the early detection of the mentally abnormal, the peculiar, and the subnormal children in our public schools, and the provision of proper care and treatment for the conditions they present, go far towards solving the problems of our future criminal and dependent classes?

In the hard facts presented in the foregoing tables there is no

sentiment. We have shown what in later life becomes of the feebleminded children in the public schools. We have shown that mental deficiency forms the very root of crime, prostitution, hereditary pauperism, and the like, conditions for which the state is spending vast sums of money.

These problems are preventable, in that the one sensible, ready, and efficient measure that can be carried out is to dam the stream near its source. As far as delinquency in the mentally defective is concerned, there need be no delinquency if the defective as such is reckoned with early.

Proper provision for the feebleminded at a time when these antisocial problems are preventable is an ideal that this state can most profitably set itself to achieve.

Expense is not an excuse. It is within our power to deal effectively with this problem, for we are already bearing the much greater expense of paying for our failure to deal with it.

It is not, then, a question of whether we wish to pay for feeblemindedness. We are doing that, and in the most costly manner possible, both in dollars and cents and in human wretchedness and misery. It is simply a question of whether we will pay blindly or intelligently—whether we will pay in crime, in courts, in reformatories, in prisons, in almshouses, or in prevention, in intelligent care and training of these feebleminded children in schools and institutions suited to their particular needs, in special-class instruction of them in the public schools, and proper supervision of them in the community.

Recommendations

I. Training School and Farm Colony for Feebleminded Persons

(A) Custodial Department

This department includes the lower grades of idiots and epileptics. Some of these children are as helpless as infants, incapable of standing alone or of dressing or feeding themselves. The chief indication with these lower-grade cases is to see that their wants are attended to and to make them comfortable and happy as long as they live; but even with these cases, much improvement is possible in the way of teaching them to wait on themselves, to dress and undress, to feed themselves, and to give attention to personal cleanliness and habits of order and obedience. In this way, quite a large group, even of these low-grade cases,

may be made less troublesome, and the burden and expense of their care may be considerably lessened.

(B) The Training School

Here manual training and other methods are especially adapted to the training of feebleminded children. Dr. Walter E. Fernald has said "these methods of physiological training of the senses and faculties, of exercising and developing the powers of attention, perception, and judgment, by teaching the qualities and properties of concrete objects, instead of expecting the child to absorb ready-made knowledge from books, of progressively training the eye, the hand, and the ear, these were the methods formulated by Séguin," etc.

Dr. Fernald further says: "The most prominent feature of our educational training to-day is the attention paid to instruction in industrial occupations and manual labor. In this 'education by doing' we not only have a very valuable means of exercising and developing the dormant faculties and defective bodies of our pupils, but at the same time we are training them to become useful men and women. Carpentering, painting, printing, brick-making, stockraising, gardening, dairying, farming, domestic work, the manufacture of clothing, boots and shoes, brooms, and brushes, and other industries are now successfully carried on by the pupils in these schools, in connection with the strictly mental training."

(C) The Farm Colony

An essential part of this school for the feebleminded is the farm colony that should be attached to it. A large proportion of the feebleminded can be usefully and profitably employed, if intelligently directed. They can clear waste land, grub bushes, remove stones, build fences, make roads, renovate orchards, drive teams of oxen or horses, milk cows, feed pigs, take care of chickens, cultivate land, and gather crops. They can excavate for buildings, haul stones for foundations, make brick and cement blocks, and do the necessary painting to keep the buildings neat and attractive. In states where the colony plan has been utilized and intelligently directed—as at Templeton, in Massachusetts, under the direction of Dr. Fernald—large crops have been yearly grown and unusual success has been obtained from this method of treatment. Many of the children who, at the training school, found the necessary restraint irksome, are free at the farm colony to go and come. They may wander freely in the woods, and if

there is a stream nearby, they may go in bathing. The results of their labor become more evident. Where they make their own concrete blocks and construct their own buildings, they feel that they are really doing something worth while, and appreciate the fact that they are making their own home. The destructive tendencies often marked in the schoolroom find their outlet here. Instead of breaking windows, destroying furniture, or setting fire to buildings, as these children so often do when confined in penal institutions, they cut down bushes, pull up stumps, burn brush heaps, and make waste land available for farming, thus increasing its value and decreasing the cost of maintaining themselves as the wards of the state.

(D) Kind of Land and its Location

Cheap land should be bought, with good water and drainage facilities—undeveloped land that can be made useful and valuable by clearing, draining, and preparing for cultivation. This work the feebleminded can do. Barren or near-barren land must not be selected. The location should be far enough away from cities so that it can be purchased for its inherent agricultural value, but not so far as to be inaccessible. The more accessible the feebleminded person is to his family and friends, when in the institution, the more readily will the latter consent to such care.

(E) Type of Buildings

The feebleminded can be economically housed if we discard the mistaken idea of elaborate buildings and equipment. At the same time, they can be made happy, useful, and contented. Simple buildings, not more than two stories high, of frame, cement, or cement block, may be used. It is probably more economical to build with concrete blocks, where the boys can do a large part of the work themselves. The buildings should house from fifty to one hundred persons each. This presents the possibility of segregation of different types. Not only can the negroes be separated from the whites, and the boys from the girls, but the vicious and delinquent types from the more tractable types, the high-grade cases from the low-grade, the epileptics, etc.

(F) Medical Superintendent

It is probably needless to add that, inasmuch as the innumerable problems confronting the superintendent of such an institution are so essentially medical in nature, having to do with the various physical and mental aspects of feeblemindedness, only a physician trained in this particular field should be at its head.

II. Special Classes in the Public Schools

In every school district throughout the state, there are children who are not receiving educational benefit commensurate with the effort and money expended on them. These children are a drag on the classes. These backward children have just as much right to education as the normal child. This education can be made of the largest profit to the child and to society if it is directed along lines that will give him industrial training and habits fitted to his particular capabilities and adaptabilities.

Through the organization of special classes, the normal class and the teacher are relieved of a drag. "The retarded and slow children are encouraged and speeded up." "The intractable children become interested in school work." The defective children are trained to do the things they are capable of doing. By proper correlation of the work of these special classes with the State Institution for the Feebleminded, many of these children may be prepared for happy and useful lives under state supervision.

III. State-wide Supervision

If these special classes in the schools are to be of the greatest service, then some plan of supervision and control of the feebleminded is necessary. Are we to look after these defective children in the special classes in schools until they are fourteen, fifteen, and sixteen, and then suddenly throw off all responsibility and turn them out into the community? The school and the special class furnish us with a nucleus for a system of supervision, enable us to detect early the feebleminded child and to give him proper supervision or institutional care. If, now, there is accessible to the school and the special classes (1) a mental clinic for the detection of the feebleminded child and the diagnosis of his particular possibilities, capabilities, and adaptabilities; (2) a social-service department, containing workers to act as visiting teachers, keeping in touch with both child and home; and (3) a vocational and employment bureau, we have the beginnings of an effective machinery for supervising the feebleminded in the community. The need for some properly constituted authority to take on the supervision of the feebleminded is urgent. As Dr. Fernald has well said, "At any given time it is a matter of chance as to what state or local or private organization is being perplexed by the problems they present. They are shifted from

one organization to another as soon as possible." There should be some authority to advise and compel proper care and protection for this numerous and dangerous class.

IV. Mental Clinics

The creation of mental clinics throughout the state, manned by the staffs of the state hospital for the insane and the school for the feebleminded, to act as clearing houses for the defective, the subnormal, the peculiar, and the nervous children of the public schools, the abnormal and delinquent children of the juvenile court, and the various complex mental problems in the home and in the community, will do much toward the prevention of insanity, pauperism, and criminality in the oncoming generation.

V. Laws for the Commitment of the Feebleminded

There should be laws containing provisions for the diagnosis, commitment, parole, and discharge of feebleminded persons, stating who are qualified to diagnose feeblemindedness and making the usual provisions for the protection, care, training, and segregation of mental defectives.

A STATE PROGRAM FOR THE CARE OF THE MENTALLY DEFECTIVE

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IT is now generally understood that the feebleminded and the progeny of the feebleminded constitute one of the great social and economic burdens of our modern civilization. We have much accurate knowledge as to the prevalence, causation, social significance, prevention, and treatment of feeblemindedness, its influence as a source of unhappiness to the defective himself and to his family, and its bearing as a causative factor in the production of crime, prostitution, pauperism, and other complex social diseases. The literature on the subject has developed to enormous proportions. An intelligent democracy cannot consistently ignore a condition involving such a vast number of persons and families and communities, so large an aggregate of suffering and misery, and so great economic cost and waste.

Nearly every state in the Union has already made a beginning in the way of a program for dealing with the mentally defective, either directly or indirectly. The development of this program in the different states varies greatly in degree and method. Even the most advanced states have not yet formulated a plan for reaching all of the feebleminded of the state. It is safe to say that no state has yet officially taken cognizance of 10 per cent of the mentally defective persons in that state. No state has even ascertained the number of feebleminded in the state, their location, or the nature and expression of their defect. The great majority of these defectives receive no education or training and no adequate protection and supervision. We know that feeblemindedness is highly hereditary, but in most states there is no legal obstacle to the marriage of the moron, the most numerous class of the feebleminded.

There are many reasons for the lack of a formal accepted program. The problem cannot be solved by a simple formula, which can be expressed in one definite piece of legislation. It is an infinitely complex problem, varied according to age, sex, degree and kind of defect, presence or absence of hereditary traits or criminal and antisocial proclivities, home conditions, etc. The

* Read at the Child's Welfare Conference called by the Children's Bureau of the Department of Labor, and held at Washington, D. C., in May 1919.

idiot, imbecile, and moron present different needs and dangers. Each of these groups has different troubles, according to age and sex. Rural, sparsely settled communities, with homogeneous racial populations, have conditions pertaining to the defective which differ from those of urban industrial centers, with cosmopolitan racial complications.

The first step in a rational program would be the beginning of a complete and continuing census of the uncared-for feebleminded of the whole state—this would state and define the problem. Many privately conducted surveys show the feasibility of such a census. The data for this census would be furnished by physicians, clinics, court and jail officials, social workers, town officials, teachers, etc. No doubtful case should be registered. Only those persons whose mental defect has been scientifically diagnosed should be registered. The register should be highly confidential and accessible only to properly accredited persons.

This coördination of existing records would be available for social workers, school authorities, and other agencies, and would be of enormous service in the solution of the individual problems which the feebleminded constantly present. This alone would mean a great saving in time, effort, and money. This official census would give a logical basis for intelligent management of the mental defectives of the state.

A census of the feebleminded would make possible and desirable some provision for a central governmental authority responsible for the general supervision and assistance and control of the uncared-for feebleminded of the state who do not need immediate institutional commitment. This state supervision of the feebleminded should be directed by a state commission for the feebleminded, or a properly constituted state board of health, or other similar body. Its responsible officer should be a psychiatrist, with special knowledge of mental deficiency and its many social expressions.

The local administration of this supervision could be carried out by the use of existing local public organizations, existing local private organizations and societies, or by properly qualified volunteers in each community. These peripheral workers could be made efficient by the use of suitable manuals, etc. This systematic supervision of the feebleminded could easily be made to cover the entire state, with a local representative in each community, but all under the direction of the central authority.

Each defective could be regularly visited and kept under observation by the local visitor. The reports of these visitors, covering the life histories and the family histories of many cases, would soon constitute an invaluable treasury of information as a basis for scientific research and study in the search for practical methods of prevention. The official visitor would advise the parents as to the care and management of the defective, and would have opportunity to inform the family, the local officials, and the community generally as to the hereditary nature and the peculiar dangers of feeblemindedness.

The registration of every feebleminded person, and the regular visitations, especially of children of school age, would make it possible to inform the parents of the condition of the child, of the probable necessity of lifelong supervision, and of the possible need for future segregation. Suitable, tactful literature should be prepared, which could be gradually presented to the parents in a way that would have great educational value. Sooner or later, the parents would probably be willing to allow their child to be cared for and trained in an institution if he needed such care. In suitable cases parents should be allowed to have the custody of their child, with the understanding that he shall be properly cared for and protected during his life, that he shall not be allowed to become immoral or criminal, and that he shall be prevented from parenthood. Whenever the parents or friends are unwilling or incapable of performing these duties, the law should provide that he shall be forcibly placed in an institution or otherwise safeguarded. The local representatives of the central bureau would officially serve as advisers and sponsors for pupils graduated from the special school classes, for court cases under probation and observation, and for institutional inmates at home on visit or on trial.

Under this plan there would be a person in every locality familiar with the opportunities for mental examination and methods of permanent commitment. The extra-institutional supervision and observation of cases in their homes would do away with the necessity of institutional care of many persons who would otherwise have to go to an institution, thus reducing the expense of buildings and maintenance.

There should be legal provision for the commitment of uncared-for defective persons to the permanent custody of the central authority. This commitment should formally recognize the

actual mental age and degree of responsibility of the defective person so committed. The legal status of a defective should be that of a normal child with a mental age of eight, nine or ten years. The permanent eight- or nine- or ten-year mentality of the defective should be legally acknowledged.

The extra-institutional supervision should include cases dismissed from institutions, so that the defective who has spent many years in an institution would not be thrown out into the world with a freedom which he does not know how to utilize. In these cases, the supervision would constitute a permanent parole which would be most effective. This provision would enable the defective to be returned to the institution if he did not properly conduct himself in the community. Such provision for registration of the feebleminded and for extra-institutional supervision would insure that those defectives who most need institutional training and protection would be sent to the institutions, and that those who can live safely and happily in the community would be allowed to do so.

The keynote of a practical program for the management of mental defectiveness is to be found in the fact, which seems to have been proved, that those defectives whose defects are recognized while they are young children, and who receive proper care and training during their childhood, are, as a rule, not especially troublesome after they have been safely guided through the period of early adolescence.

Every child automatically comes under the control of the school authorities between the ages of six and fourteen. Every case of mental defect can be easily recognized during this period. Present methods of health examination of school children could easily be extended so as to insure and require a mental examination of every child obviously retarded in school accomplishment. It would not be necessary to give a mental examination to all the school children. It would be sufficient to examine only those children who are three or four or more years retarded in school work—perhaps 2 or 3 per cent of the primary-school population.

In the large cities, the mental examinations could be made by special examiners and at mental clinics. The rapid development of out-patient mental clinics all over the country will soon furnish facilities for such examinations in all the large cities. Rural communities and small towns could be served by a traveling mental clinic, as a part of the state government. This clinical

group, or even a single clinician, could examine the presumably defective children over a very large area. A visit to each small town once each year would be sufficient. Every institutional school for the feebleminded should conduct out-patient mental clinics at the institution and in the various cities and towns served by the school. At the time of the mental examination, the parents should be informed as to the mental condition of the child and of his need for special training and protection.

Suitable manuals should be prepared by the state board of education, which could be placed in the hands of every teacher, especially in the rural schools, describing the methods of training and management that should be applied to these cases. It should be recognized that the defective child is entitled, even more than a normal child, to education according to his needs and capacity. The defective children who cannot be taught in the regular schools should be referred to the special classes or the institutional schools.

Cities and towns of over five thousand population are likely to have groups of at least ten or more defective children. Such communities should be required to establish special classes for defective children. The proper authorities should decide upon the courses of study and the equipment of school materials which are necessary for these special school classes. Provision should be made in the normal schools for training teachers of defective children. Every normal training school for teachers should be required to give suitable instruction to teachers, to enable them to recognize probable cases of mental defect and to give them a general idea as to the training and discipline of such children. The state board of education or some other branch of the state government should prepare simple manuals of facts for the use of the parents of feebleminded children. This literature should be prepared in series, with special articles for young boys, for young girls, for older boys, for older girls, and for other groups, and should kindly and tactfully instruct the parents as to the limitations of these children in the way of scholastic acquirements, and emphasize the importance of the development of habits of obedience and industry and the necessity of protection against evil influences and companions during the formative period, and of the possible need of institutional care in the future.

The great majority of mental defectives are of the moron group. If the plan suggested for the early recognition and the intelligent education and training of the moron in public schools and at home

is carried out, many of this class can be safely cared for at home. We have begun to recognize the fact that there are good morons and bad morons, and that it is often possible in early life to recognize the moron with antisocial and criminalistic tendencies, who will probably need institutional care. Morons from families unable properly to protect and control their children will need institutional training and care. The fact should be emphasized that the neglected moron is the defective who makes trouble later in life, and that during the formative period of his life he should receive proper care and training either at home, with the special help of the regular teacher or the special class, or in an institutional school.

The special public-school classes also serve as clearing-houses for the recognition of defective children who are markedly antisocial and immoral, and who need permanent institutional care. It is an easy step from the special class to the institution. The children who graduate from the special school classes should have the benefit of follow-up or after-care assistance and help.

In the majority of states, the only provision for mental defectives is furnished by an institutional school for the feebleminded, providing care and protection for a limited number of idiots and imbeciles, education and industrial training for morons, with permanent segregation for a certain number of defectives, and with special emphasis upon the lifelong segregation of feebleminded women of the hereditary group. It was formerly believed that it was possible and desirable to provide institutional care for practically all the mental defectives of the state. This was before the actual extent of the problem was known and its cost computed, and before the difficulty of securing the commitment to an institution of many of these cases was realized. In practice it has been found very difficult to insure the lifelong segregation of the average moron. The courts are as ready to release the defective as they are to commit him in the first place. However proper and desirable it may be in theory to insure the lifelong institutional segregation of large numbers of the moron class, it is a fact that there is a deep-seated prejudice on the part of lawyers, judges, and legislators towards assuming in advance that every moron will necessarily and certainly misbehave to such an extent that he should be deprived of his liberty. That such misgivings are well-founded is apparently shown by the studies made of discharged patients at Rome and Waverley. At Waverley, a

careful study of the discharges for twenty-five years showed that a very small proportion of the discharged male morons had committed crimes, or had married, or had become parents, or had failed to support themselves, or had been bad citizens.

It has been fairly well demonstrated that the average male moron, without naturally vicious tendencies, who has been properly trained in habits of obedience and industry, and who is protected from temptation and evil associations during his childhood, can be safely returned to the community when he has passed early adolescence, if his family are able to look after him and give him proper supervision. A very much larger proportion of these trained male defectives would be suitable for community life if the above-described extra-institutional control and supervision could be provided.

The average citizen is not yet convinced that he should be taxed to support permanently an individual who is capable of 30 or 50 or 70 per cent of normal economic efficiency, on the mere theory that he is more likely than a normal individual to become a social problem. Thousands of morons never give any trouble in the community.

The after-care studies of the female morons who have received training in the institutions were not so favorable, but many of these, too, led moral and harmless and useful lives after their return to the community. The study of discharged female cases at Waverley showed a surprisingly small number who became mothers or who married. While it is true that defectives with undesirable habits and tendencies are not easily controlled, it is equally true that defectives who are obedient and moral and industrious are apt to continue these traits permanently. It is as difficult for them to unlearn as it was to learn. Those defectives whose tendencies are such as to make them undesirable members of the community should not be allowed their liberty, but should be permanently segregated in institutions. No other class of human beings so surely avenge neglect in their childhood, socially, morally, economically, and eugenically.

Defectives who develop markedly immoral or criminalistic tendencies in the institutional schools for the feebleminded should not be retained permanently in the institutions devoted to the care and training of the average defective, for the feebleminded are most suggestible and easily influenced and should be protected from the companionship and influence of the defective with

criminalistic tendencies. These "bad" defectives should be committed to and cared for in an institution especially for that type, where the discipline could be made more rigid, and permanent detention more certain.

If 25 per cent or more of the inmates of our penal and correctional institutions are feebleminded, as has been shown, it should be required that a mental examination should be made of all inmates of such institutions, and that those criminals who are found to be mentally defective should not be automatically discharged, to return to the community, but should be committed to a special institution for defective delinquents, and should be permanently segregated, and discharged only under the strictest sort of supervised parole. Provision should be made for the mental examination of all persons accused of crime when there is any suspicion as to the mentality of the accused.

There is no doubt that every state in the union needs greatly increased institutional facilities for the care of the feebleminded, not only as a matter of justice and fairness to the feebleminded themselves and to their families, but as an investment that would repay the cost many times over.

There is no panacea for feeblemindedness. There will always be mentally defective persons in the population of every state and country. All of our experience in dealing with the feebleminded indicates that if we are adequately to manage the individual defective, we must recognize his condition while he is a child, protect him from evil influences, train and educate him according to his capacity, make him industrially efficient, teach him to acquire correct habits of living, and, when he has reached adult life, continue to give him the friendly help and guidance he needs. These advantages should be accessible to every feebleminded person in the state. Most important of all, so far as possible, the hereditary class of defectives must not be allowed to perpetuate their decadent stock. The program for meeting the needs of these highly varied and heterogeneous groups must be as flexible and complex as the problem itself. It will be modified and developed as our knowledge and experience increase.

To sum up, the program now possible includes the mental examination of backward school children; the mental clinic; the traveling clinic; the special class; directed training of individual defectives in country schools; instruction of parents of defective children; after-care of special-class pupils; special

training of teachers in normal schools; census and registration of the feebleminded; extra-institutional supervision of all uncared-for defectives in the community; selection of the defectives who most need segregation for institutional care; increased institutional facilities; parole for suitable institutionally-trained adult defectives; permanent segregation for those who need segregation; mental examinations of persons accused of crime and of all inmates of penal institutions; and long-continued segregation of defective delinquents in special institutions.

The above program would require team work on the part of psychiatrists, psychologists, teachers, normal schools, parents, social workers, institution officials, parole officers, court officials, prison officers, etc. There would be a highly centralized formulation of plans and methods and of authority, but much of the real work would be done in the local community. The degree of development of the program in a given state would depend upon existing knowledge and public sentiment on the subject in that state and this in turn would be measured by the wisdom and experience of the responsible officials. Nearly every suggestion in the proposed program is already being followed in some state. No one state has anything like a complete program.

DEMENTIA PRAECOX AS A SOCIAL PROBLEM

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IT has long been known that dementia-praecox patients constitute a large part of the chronic cases in state hospitals for mental disease, but it was something of a shock to learn, when the first census of the psychoses of the patients resident in the New York State hospitals was taken on July 1, 1916, that of the total patient population of 35,213, 18,940, or 53.81 per cent, were cases of dementia praecox. The census taken a year later showed that these cases had increased to 19,544; the percentage, however, had remained practically the same. The number of dementia-praecox first admissions to the civil hospitals during the fiscal year ending June 30, 1917, was 1,475, or 21.4 per cent of the total first admissions, and the number of deaths in the group was 852. Excluding transfers, there were 674 discharges and 469 readmissions. The total number of dementia-praecox cases under treatment during the year was 21,070.

These data give a glimpse of the magnitude of the problem, but they do not tell the whole story. Kirby and Bleuler have called attention to the fact that certain dementia-praecox cases develop without hallucinations or pronounced trends of any sort and, on account of the absence of psychotic symptoms, rarely reach the state hospitals, but become chronic loafers, beggars, tramps, and poorhouse inmates. The number of these useless human beings is not known, but the burdens they impose on society are exceedingly heavy.

The significance of the 19,544 institution cases of dementia praecox may be better seen by comparison with other wards of the state. On June 30, 1917, the number of prisoners resident in the five state prisons was 4,509; the number of feebleminded in state institutions was 3,461; the number of epileptics, not feebleminded or insane, cared for by the state was 1,466; and the number of all classes of inmates in the other state charitable institutions was 4,572. The combined population of the five state prisons and the eighteen state charitable institutions on that date was 14,008—or 5,536 less than the number of dementia-praecox cases in the civil state hospitals. If the dementia-praecox patients now in our state

hospitals were removed, nine of the thirteen hospitals could be closed and the remaining four would have 752 less patients than at present. The net increase of dementia-praecox patients in our civil state hospitals last year was 614. If this rate of increase continues, as it probably will, a new institution of the size of the Middletown or Buffalo State Hospital will have to be built every three years to provide for this *one* class of patients alone.

In our recent statistical studies of the various psychoses, we have obtained a general view of dementia-praecox patients, so that we can now state some fairly positive facts concerning the group as a whole. With respect to age, we find that of every 100 dementia-praecox first admissions, 8 enter the hospital before reaching the age of 20 years, 43 enter between the ages of 20 and 30 years, and 30 between the ages of 30 and 40 years; the remaining 19 are 40 years of age or over at the time of admission. Marked differences appear between the ages of the male and of the female first admissions. Sixty per cent of the male cases and only 41 per cent of the female cases are under 30 years of age at the time of admission. Eighty-nine per cent of the males and 71 per cent of the females are under 40 years of age. The percentages of cases between the ages of 30 and 40 years are practically the same in both sexes. The fact that 49 per cent of the cases are 30 years of age or over at the time of admission shows that dementia praecox can not be considered as *insanity of youth* as the term implies.

The percentage of dementia-praecox first admissions with unfavorable family histories varies from year to year, but our statistical reports indicate that approximately 50 per cent of the ascertained cases have family histories of insanity, nervous diseases, alcoholism, or neuropathic or psychopathic traits. On the other hand, approximately 50 per cent of ascertained cases have no unfavorable family history.

With respect to original mental make-up, we find that 46 per cent of the ascertained cases are temperamentally normal; 54 per cent, temperamentally abnormal; 78 per cent, intellectually normal; and 22 per cent, intellectually abnormal. The temperamental peculiarities in some cases may be the beginnings of the disorder rather than an inherited defect.

Alcohol is an assigned etiological factor in approximately 4 per cent of the cases, and the intemperate use of liquor is reported in an additional 8 per cent. These percentages vary somewhat from year to year.

With respect to marital condition at the time of admission, we find that 65 per cent are single; 27 per cent, married; 4 per cent, widowed; and 4 per cent, divorced or separated. The males differ markedly from the females with respect to marital condition. Of the males alone, 79 per cent are single and 16 per cent, married; while of the females, 50 per cent are single and 38 per cent, married. The percentage of single patients among first admissions of all groups is 46, and of married 39. The failure of such a large proportion of these patients to marry would seem to indicate that dementia praecox is not, like feeblemindedness, a self-propagating defect condition.

With regard to school training, we find that 67 per cent of the dementia-praecox first admissions are reported as being of common-school grade; 7 per cent as having a high school education; and 1.3 per cent as having taken a college course. These percentages vary but slightly from those obtained for the first admissions of all groups.

With respect to economic condition, we learn that 17 per cent of the dementia-praecox first admissions are dependent; 83 per cent are self-supporting, 75 per cent being in marginal circumstances, and 8 per cent in comfortable circumstances. The percentages of dependent, marginal, and comfortable for all first admissions are 17, 71, and 12 respectively.

The dementia-praecox cases come principally from cities. In 1917 the percentage of urban first admissions was 92.5 and of rural, 7.5; while the per cent distribution of the general population of the state in 1910 was 78.8 and 21.2 respectively. The rate of dementia-praecox first admissions per 100,000 of the general population in 1917 was 17.3 in cities and 5.2 in rural districts.

With respect to occupation, we find that dementia-praecox patients come from all branches of industry, but the rate of incidence of the disorder varies greatly in different occupations. It is higher in indoor than in outdoor occupations, and in domestic and personal service than in other indoor occupations. The highest rate of incidence is found among servants and laborers. Many cases come, however, from manufacturing and mechanical industries, and from clerical and professional service. Of the 3,483 male dementia-praecox first admissions admitted to the civil state hospitals from October 1, 1909 to June 30, 1916, 96 came from the ranks of the professions: 18 were musicians; 16, draftsmen; 10, teachers; 7, artists; 6, lawyers; 4, dentists; and 3, physicians. There were no statisticians among them.

It is well known that the hospital treatment of dementia-praecox patients results in complete cure in but very few cases. Of the 21,070 cases under treatment in the civil state hospitals during the fiscal year of 1917, 21 were discharged as recovered; 247 as much improved; 272 as improved; and 134 as unimproved. It is probable that most of the cases discharged will return to the hospital. The total number discharged benefited by treatment equals approximately 28 per cent of the total dementia-praecox admissions of the year. In the other groups of psychoses the percentage was 41.5. Eight hundred and fifty-two dementia-praecox patients died in the hospital. The average age at death was 50 years. The death rate per 1,000 under treatment was 40.4. The average time spent in hospitals for the insane by the dementia-præcox patients who died was 16 years. This period is considerably longer than that spent by the average patient in any other clinical group. The general average period spent in hospitals by patients of all groups who died in the hospitals in 1917 was 6.3 years. The general average period of all patients other than dementia praecox was 3.5 years.

In treating dementia-praecox patients in the hospital, it is found that about half of the younger cases can be taught to do useful work and some become fairly efficient hospital workers. Besides instruction in industrial work, some physical training is given and a few accessible cases are helped by psychoanalysis. As the disorder is generally regarded as incurable the aim of treatment is to make the patient as useful and comfortable as possible and to prevent further deterioration.

Here, then, is our problem in the state of New York. We have 20,000 apparently hopeless dementia-praecox patients to be cared for at public expense for an average period of 16 years; 1,500 new cases are coming into the civil state hospitals each year, causing a net annual increase of 600. We do not know the fundamental causes of the disorder and we do not know how to cure or prevent it. What is to be done? I ask this question here [Conference, New York State Hospital Physicians] because the state is looking to us for an answer. Shall we be content to let the accumulation of these cases go on indefinitely? Shall we assume a pessimistic attitude and say that nothing can be done? Shall we wait until the problem is solved by some one else? Or shall we take up the problem and solve it ourselves? We have competent investigators, psychiatrists, pathologists, social workers, and statisticians

who might jointly study this problem under the guidance of the director of the Psychiatric Institute. If more funds are needed, I am sure the state will supply them. A hundred thousand dollars a year might well be spent in learning how to prevent and cure a malady that now involves annual direct and indirect losses to the state of more than $10,000,000.

If some unknown physical disease should strike down and kill 1,000 young people in this city during the current year, do you think the medical profession, the newspapers, and the public generally would view the matter with complacency? Yet dementia praecox will come into this city [Brooklyn] as a masked enemy and steal away the minds of 1,000 young men and young women and condemn them to a living death during this year, 1918, and scarcely any public mention of the matter will be made.

Disease prevention is a comparatively new field of scientific endeavor, but within the past thirty years many virulent diseases have been conquered and the average span of human life has been greatly lengthened. Until recent years attempts to combat mental disease have been unavailing, but now great progress is being made in the elimination of the causes of alcoholic insanity and of general paralysis. Our victories in these fields should give us courage to undertake the much more difficult drive against our most insidious enemy, dementia praecox.

THE EXPERIMENT IN OCCUPATIONAL THERAPY AT BASE HOSPITAL 117, A. E. F.

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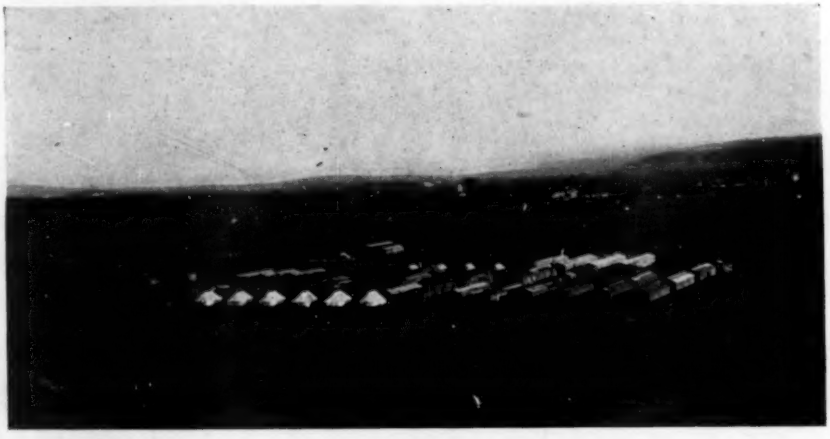
THE importance of the experiment in occupational therapy that was carried out at Base Hospital 117 at LaFauche lies in the fact that it was the first time that this form of treatment was put into effect in a military hospital under what must be considered forward-area conditions. In the early days of June, 1918, this hospital was in the advanced section of the S. O. S., about twenty-five miles from the front line. The further significance of the workshop in this hospital is associated with the kind of patients that were treated there. Base Hospital 117 was a special hospital planned to treat cases of war neuroses as soon as they could be taken there from the front lines. The character of the cases, and the fact that an attempt was made to treat them with all the methods that were in vogue in the best equipped hospitals in the back and in the home area, form the two striking features of the test that was to be given to a form of therapy which up to that time had been reserved for hospitals at base ports or for those forming a part of hospital centers or such hospitals as had the advantage of being in the environment of home conditions, where the problem of obtaining shop, tools, and workers was not present.

In describing the methods that were carried out there, it must not be forgotten that Base Hospital 117 had a particular problem to solve in a medical way and that the necessity for a proper solution of this problem was never permitted to escape the minds and interests of the medical and nursing staff or of the civilian aids who ran the workshop.

A case of war neurosis is generally a soldier who is in good physical condition—that is, who is organically sound. He is not wounded as a rule, and generally he has no evidence of disease in the ordinary meaning of the term. His physical fitness, then, gives him a certain potential value as a soldier. The thing that prevents him from being so is the fact that he has failed to adapt himself to the conditions that are before him as a result of a shock to his nervous system. This failure in military adaptation shows

Red Cross hut and occupational-therapy workshop of Base Hospital 117



Panoramic view of Base Hospital 117

Entrance to officers' chateau

itself in the form of one of the types of war neuroses. It is not necessary here to go into the mechanisms of the neuroses or to point out any of the symptoms, but merely to characterize the clinical problem from the point of view of the attack to be made upon it by the method of occupational therapy.

A part of the definite problem that these cases presented was due to the fact that it was of prime importance to cure these patients as promptly as possible and to return them to duty in front-line work if possible, or at least to some active participation in the fighting area. This was necessary for two reasons: first, the leakage through an increase in the number of war neuroses would become serious from the point of view of morale and man power and, second, the physically fit must be considered as the best possible material for replacements or return to the lines. The therapeutic problem in general was focused upon these simple considerations and in the occupational phase of it the same ends had to be kept constantly in view. Never before, perhaps, had a form of treatment to undergo so severe a test and pass through its test under such primitive and difficult conditions. That the work therapy and the aids who conducted the shop succeeded means that the principle of the efficacy of work in the treatment of the neuroses, of the war type at any rate, has been established. A method of treatment that can meet its purpose so surely and definitely as this did would seem to have something of the adaptability of a proven thing. Conditions of actual warfare form the most severe test of any method of treatment, and if a method comes through the test, proving itself serviceable and adaptable, then it becomes a necessary routine for the same sort of condition met with in any kind of environment.

Occupational therapy previous to the war was looked upon as a kind of luxury in a hospital able to afford unessential things of that sort. It was approved, as a rule, in institutions for the insane because it had its origin there in the use of manual labor on the part of the patients in various types of agricultural tasks. It grew, therefore, from a beginning that showed its practical success both in the effect on the patients and in the influence it had on the visitors. The products of the garden and the field made a ready appeal to the boards that controlled the policy of the institutions. There has never been much objection to the introduction of the principle of occupational therapeutics in institutions for the treatment of the insane. In other places the notion

of work as a well defined and logical method of treatment has had a difficult time of it, and it is only recently that its recognition has come from all sides.

The principles that guide the use of occupational therapy are in process of being established, gathered together from the various experiences in which this method of treatment has shown its adaptability and its utility. In the treatment of the neuroses it has found its chief application, and in the war neuroses especially it has developed almost into a routine. The utilization of occupational therapy in some of the more advanced sanatoria in the United States is, of course, well known, and the work of Dr. Hall in Marblehead in this connection needs only to be mentioned. It is not necessary to recall to mind other places where recognition has been given to this form of treatment, or to note that work as a method of treatment in the neuroses is not a new idea. Many years ago, Grohmann, a Swiss engineer, in an institution in that country, developed the technique, and very little, so far as general application is concerned, can be added to his work. What is new, however, is the use of a workshop in a forward-area hospital, under conditions found in an army hospital, in the treatment of acute cases of war neuroses.

In Base Hospital 117 the use of work as a curative agency sprang in the first place from the necessities of the hospital in the early phase of its development. Before the regular staff had arrived and before the equipment had been brought over, when the hospital was simply an old field hospital with a few wards and a few medical officers, it received about fifty cases of what were afterwards called anticipation neuroses. These were soldiers who had never seen active service and had never been anywhere near the front lines, but had developed their neuroses either in America before sailing or en route to France. They presented a very unfavorable type of case, as may well be imagined. They were not war neuroses in the real sense of the term, never having been exposed to the traumata of warfare, but they presented symptomatically all the evidence of the most severe types of this condition. Treatment was extremely difficult because there was little either in temperament or make-up to build upon. They represented as a whole the so-called neuropathic types of soldiers, the kind that were not at all adapted to the conditions of warfare. They would have been excluded from the army if at that time there had been in force the methods of elimination adopted later.

The hospital was much handicapped on account of the lack of

roads and pathways between the rows of huts. It had been laid down on a field, and the wet and rainy winter had left it in a condition that prevented traffic of almost any kind through it. The first essential, then, was to build a road through the hospital connecting with the well-made French road leading from the highway to the village of LaFauche. Patients of all sorts were put to work breaking up stone and carrying it to make a foundation for a macadam road. The use of the stone-breaking hammer and the carting of the stone to the roadbed employed these patients for a number of weeks until the road was completed some time in May. The road was a model in its way and showed its value when the hospital grew to its largest capacity of some twelve hundred beds.

There was, of course, in this use of occupational therapy none of the refinements that were afterwards developed, and no attempt was then made to emphasize the localization of therapeutic effort. It was occupation therapy in the broadest sense, and it had its effect on the patients simply because it gave them something to do and showed to those with paralyses and tremors that it was possible for them to carry out coördinated movements and to make use of their muscles in the production of tangible results. From this very crude beginning the therapeutic workshop, when it arrived for duty, found that the principle of work had been already established. The value to the individual patient was difficult to establish, as with this class little in the way of permanent improvement could be expected. Some of them did show rather good effects, and it was interesting to note that very few of them objected to this rather monotonous and tiresome form of work. The breaking of stone gives a good deal of opportunity to train coördination, and the use of a certain amount of skill is necessary in order to prevent injury to the hand holding the stone to be broken. The evidence of effort could be measured by the increasing pile of material, and the fact that this work was supplying a very practical need, of which the finished portion of the road was the witness, formed the essential elements upon which the efficacy of any work scheme in treatment is based. It accentuated further the fact that the type and kind of work are not of importance, nor is the output, either in quantity or quality, significant. The things that count, however, are the physiological and psychological features that result from effort to overcome resistance. The crude and primitive employment of breaking into

smaller fragments a bit of stone in order to build a road may be taken as an example upon which to base the principles of a work therapy on a more extensive scale. The very primitiveness of the instruments used and the use of the product suggests that something inherently deep down in man's make-up is touched in this performance. Road making is an ancient calling no doubt, and the soldier responded to this as he perhaps might not have to a more intricate job.

The point is that in its therapeutic effect work is based upon very simple elements and that these simple elements should always be thought of in planning an individual application. If the performance of breaking rock for the making of a road is examined, it will be found that certain necessary elements enter into it, and if a more intricate kind of work is studied, it, too, will be found to represent only modifications of these very primitive elements. If a problem of work therapy is studied as far as the neuroses are concerned, there appear certain requirements that must be met. These features are of two kinds—one is primarily mental or psychological; the other is physiological or mechanical. These features apply also to the two sorts of individuals with war neuroses that benefit from the work treatment. One needs it because there is some defect in coördination in a broad sense, and the other because there is some psychological readjustment that demands attention. The exercise in coördination is found in the precision that is essential in using the hammer and in carrying out the necessary maneuvres in preparing and in handling the crude material. There is added to this an additional element that tends to produce precision of motion, and that is the danger of hurting the hand if the blow is not struck right. This makes for concentration and attention and brings into play the use of the eye at first to a great extent, and then develops an automaticity of movement that overcomes the excessive muscular activity that is associated with tremors and ataxic conditions. The development of strength that is muscular power comes with the practice necessary to perform a definite task. There is, too, a certain amount of noise associated with breaking stones, which was found to be a benefit to such cases as complained of being sensitive to sounds. This had to be overcome, and it was often found that the sound of the hammer against the stone was the best method of training this type of case to the usual hospital noises. The evidence of the productivity of effort could be measured by the

pile of stone that grew up by each patient. The evidence of utility was the road itself, which the patient saw slowly grow under his eyes. The psychological phase of this kind of work was found in the proof to the patient that a defect in muscular power must be only an evanescent one if a muscle group that is not acting right is capable of carrying out effectively so complicated a type of movement as handling a hammer. The evidence of sufficient muscular strength was there to be seen. The conviction was forced upon the patient, therefore, that his defect was not only a temporary one, but that it was easily curable by the simplest of procedure—that is, use. The emotionally overloaded state that so many of these patients were in could be most easily lightened by giving them a muscular outlet or rather an effort outlet. Through their hands and fingers, the emotional hypertension was sidetracked or exploded. In such routine work as this, automatic as it became afterwards in most instances, there was given to the patient an opportunity to face his own experiences if he had any or to face his present situation as it was interpreted to him by his medical officer. He could use his intelligence at the same time that he was carrying on his task.

This feature of this kind of employment therapy was used effectually in the material that came to the hospital later, when the more definite types of war neuroses, fresh from the combatant area, arrived.

The emphasis on this simple type of work therapy is given because it underlies so much of the philosophy of occupational therapy and it opens the way for the proper appreciation of just what can be expected from treatment in the more exacting sorts of work that were afterwards used. What was lacking, of course, was the effect of the shop spirit as a whole that may be developed in a well-organized shop, and the personal effect on the patient of a skillful aid or teacher. These elements can be supplied only in a shop and by the presence in that shop of trained workers.

In the month of June the arrival of the complete staff at La-Fauche and the increase in the number of available beds brought the hospital face to face with the duty it had been organized to carry out. Numbers of patients began to come, many of them showing the most severe symptoms of the war neuroses and many of them comparatively fresh from the active fighting areas. The therapeutic problem was focused in the attempt to cure these patients as promptly as possible and to return as high a propor-

tion as possible to active duty. From this time until the end of the war, some 3,000 cases of war neuroses passed through the hospital, and a large proportion took part in some kind of work during their stay or passed through the workshop as part of their treatment. It was possible to judge, therefore, with a fair approach to accuracy, just what work in this sense was able to do for them and how necessary a part of a hospital for the neuroses a workshop may be.

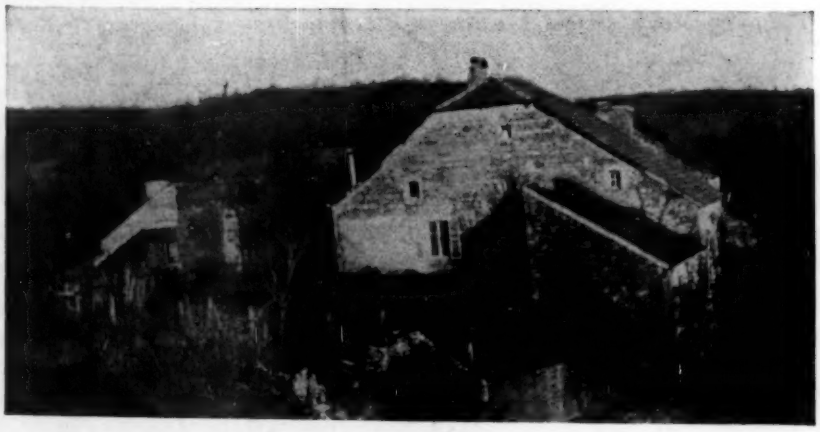
There arrived with the Unit a group of civilian workers who took the task of running the workshop in their hands, and thus the extra-medical therapy became an established thing in this hospital and was part of the routine of treatment which every patient might receive if his medical officer so desired.

Owing to lack of room, the workshop was set up at first in an unused part of a hut that had been a storeroom. A few tables were found; benches were made by the carpenter, one of the civilian aids; and in a few hours patients had been assigned to the shop for treatment. Some weeks later a special Red Cross hut was furnished to the hospital, and here were established the permanent quarters of the shop, with increased facilities which seemed to most of us very wonderful equipment considering the difficulties in the way of transportation and supply.

The evolution in work therapy from that of stone breaking and road building to the craftmanship that soon developed in the shop was a surprising and interesting thing. The shop, as a shop, began to have an influence on the patients in addition to the individual therapeutic effect of a specialized kind of work. It soon became a place where patients liked to be sent, and in its busy atmosphere of things being done many a patient passed hours during which he felt little of the burden which his condition otherwise would have produced. During the whole period of the hospital's existence, other types of work were continued, not only as a therapeutic method, but because the hospital could not have functioned without them. The policing of the hospital in the military meaning of the term—which is the cleaning up in the wards, kitchens, pathways, etc.—was practically done by the patients, and the road was kept in repair by them. Wood chopping and the cultivation of the farm land surrounding the hospital were always considered a part of the duty of patients, and they were told that in doing these things they were carrying out in a practical way the prescription of the physicians who were treating

Courtyard of officers' chateau

Another view of the chateau



Staff club house

them. About 85 per cent of the total sick population of the hospital was always engaged in work of some kind, and most of it was done through the prescription of the medical officers in charge of the various wards.

The workshop was considered as a sort of specialized therapy directed to a more definite end, planned to treat some definite symptom or to meet some special indication, while the other kinds of work were regarded as a kind of therapeutic background underlying the whole scheme of curative effort.

A patient was kept in bed for only the shortest time possible and generally after a day or two of rest to give opportunity for a satisfactory examination, and if no intercurrent illness or other defect were found, he was ready for some kind of work, either of the general sort or in the workshop itself. There was thus given an opportunity to study the effect of work as a whole upon this class of patients in a material that was completely in control of the medical staff and that represented the same kind of condition throughout. A controlled and known large group of patients suffering from functional disease of the nervous system caused by the varying traumata of warfare was in this way made the measure and test of a method of treatment which was applied, as any method of therapy should be, according to the individual needs of each patient.

The principles of application were very simple and were based largely on the observations in the rock breaking and road building previously mentioned. The physiological and psychological needs were met by the use of muscular effort in the production of tangible articles. The handling of tools and the various movements of sawing, nailing, screwing, and hammering, and the finer and more coördinated movements of wood carving, metal work of various kinds, weaving, and tinning, as well as the much more delicate and much more emotionally inspired technique of painting, sketching, and printing, supplied the essential training that the paralysis, tremors, and choreiform symptoms needed. In a sense, all of these defects were due to an intricate psychological process in which dissociation of function was the predominant mechanism. The patient could not properly innervate a muscle group because there was a defect in the proper utilization of that group. The result was often overexaggerated movements in which the inhibitive control and the habituated minimum of effort were lacking. In the same way tremors were primarily

defects in motor control, as were purposeless and ataxic movements of the choreiform types.

Motor reëducation, at first conscious and then automatically carried out, was required. The handling of tools awakened the dormant muscle control, shocked out of consciousness for the time being, and tended to restore the normal and habitual pathways long ago acquired. The familiar grip of a chisel, the friendly feel of a hammer or a saw, reëstablished the proper integration and the proper tonal balance in antagonistic muscle groups. These, as symptoms, were acting without any physiological law or purpose. The product that was being worked at gave the necessary interest and permitted the proper concentration, so that the movements were allowed to fix themselves in the proper channels and the emotional block which stood in the way was for the time being lost sight of and the individual used his hands much in the way that was customary with him. The evidence that this was possible was before him, an evidence that no amount of persuasion or explanation alone could at times accomplish. It must not be forgotten that a large proportion of American soldiers had used tools and implements before in their civilian life, and the traditional pathways, so to speak, were present and only temporarily out of action as a result of their condition.

Something must of course be said about the product that was turned out in this shop. The illustrations show a number of interesting things in the way of toys and models, but they cannot show the silver and copper work and the various things that were produced in the tin shop or the chief products of the carpenter shop. In the latter were made chairs, benches, and all other pieces of furniture that were needed in the wards and the offices of the hospital. Filing desks and cabinets and other things of that sort were turned out as the needs of the hospital grew. It seemed that the kind of thing worked at was of no real importance and that a patient was as interested in one kind of thing as in another.

No effort was made to select the kind of work from any other point of view than that of the immediate requirement in muscle defect that was present. The novelty of producing something that the patient had perchance never thought of doing himself lent an added interest to the carrying out of the job, but further than this no special effort was made to get up any unusual interest in the thing itself. There was in this way a certain lack of rigidity in the shops that was one of its main features. Patients were sent

there not to be amused or to pass the time away, but to be cured; often the therapy was directed to the local defect of the patient and the effort was planned for that symptom and for nothing else. To some of the patients the workshop was a place where they were exposed to a more invigorating influence than was present in the ward. This was particularly so in cases of depression and of apathy, and likewise in those cases in which the prominent symptom was amnesia. In such cases the type of work and the product were of no importance whatever, nor was there a question of muscle training or education. Here the attempt was made to reassociate the separated bits of the patient's memory stream, and the stay in the shop was an extension of the effort of reassociation carried out in the medical treatment rooms by the several methods used in the hospital. The social element in the mingling with men and the doing of bits of accustomed things, the talk and the noise of a shop, the familiar surroundings, all helped to that end. The automatic arousing of interest in the things that went on about him was an important element in the restoration of the patient to his normal condition.

It must be appreciated that, as far as the workshop itself was concerned, there was no attempt made there to carry out any other form of therapy than that implied in the process of work itself. In fact, the aids were instructed to the effect that a shop was no place for developing theories of psychological treatment other than such as were naturally associated with the job at hand. The reason for this was that work in the sense in which it was used at LaFauche was primarily an objective type of treatment, and the patient was regarded as deficient in that particular respect which his definite symptoms showed. This point is of some importance because there is a marked tendency to complicate the physiological principles of work therapy with a lot of mysterious notions with respect to the influence of the personality of the instructors, the more or less artistic aspect of work in the matter of the production of beautiful things, and other aspects of the question which should not enter into consideration at all.

The fact that a soldier is put upon some piece of work that has an artistic quality in no important way divorces that exercise from the immediate object for which it is devised and that is the curing of a very tangible and evident defect. It is of little material value whether or not the patient obtains pleasure from the exercise, or whether or not it awakens in him some dormant artistic

impulse. The grim aspect of war must always be kept in the foreground, and the soldier must always feel the necessity of getting well as quickly as possible so that he can take his place again in the fighting line. This latter idea has no artistic feature at all and has nothing to do with the production of beautiful things. Of course this refers only to the task that confronts a war hospital. In civilian workshops connected with hospitals a different attitude in this respect may be perfectly admissible.

A good deal of useless sentiment has been attached to the idea of work in a therapeutic sense, and it was difficult at times to keep the atmosphere of the shop at LaFauche free from it, especially as it came to be a much visited place and there was a tendency to regard the quality of the output as of primary consequence.

It is a question whether any display of products is wise; perhaps it may even be a good thing to destroy the article after it has served its purpose in helping cure the soldier. At least, if this is not done, constant care must be taken to avoid emphasizing anything but the direct physiological aspect of work. An exception to this general principle may be found in one type of case which is now and then found in a large group of war neuroses. If there is present in any severe case a capacity for self-expression in sketching or painting, and if this expression can be carried out with a certain facility, then this tendency may be used to complete a part of the treatment that is being carried on outside the shop.

The facing of the situation, a method which implies that the patient is told not to forget, but to remember past experiences and thus learn to compromise with them instead of dodging them, may be most successfully worked out if the patient is set to sketching or drawing the details of his experiences in the front lines, particularly those that preceded or accompanied the occasion when he was shocked or traumatized.

A number of such instances were found in the material at LaFauche, and the therapeutic result was very encouraging. These patients soon learned that it was the turning of their emotionally ladened memories of terrifying experiences into pictures and sketches that gave them a definite feeling of relief, and that there was nothing in this kind of exercise that was at all in opposition to the work therapy. It was only a different way of arriving at the same result that was sought each day in their interviews with the medical officers who treated them. Of course these drawings had a definite meaning and significance and they

needed no interpretative mechanism to render them clear and distinct. As a contrast are the artistic productions of the insane, which are so often symbolically expressed and which act so often as a screen to the real meaning.

Whatever the psychical mechanism may be and whatever the place that emotion in relation to events may have, it is true that emotional states are relieved by muscular expression if this expression is tangibly directed by the patient. In this truth lies undoubtedly one of the great therapeutic agencies in work.

If the workshop in connection with a hospital, whether a military one or not, is to fulfill its largest duty, it must be regarded as a definite part of the medical organization. The patients that are sent there must always remain under medical supervision, and the treatment must be followed out by the physician who prescribes it and who has set the indication for its use. The workshop must be included, therefore, in the daily medical visit, and the patient's progress or failure to improve must be noted from day to day. It was the custom at LaFauche for the medical director to see the workshop daily, and the various ward physicians were asked to follow their patients through the shop as a necessary part of their medical duty. In this way wrong assignments to work of a particular kind would be discovered and the general reaction of patients to the tasks set for them could be determined. The most definite effect, however, was the emphasis that was placed on the purely medical aspect of the shop, and the assurance that it gave to the patients there that they were being treated for their disability in the shop just as much as they were in the wards.

Every effort was made—and, it must be confessed, sometimes without success—to combat the idea that the workshop was a sentimental adjunct to the usual routine of a military hospital close enough to the front areas to share in some of its grimness and war atmosphere. The presence of the civilian workers sometimes gave the impression, to the casual visitor at any rate, that that part of the hospital lacked some of the spirit of earnestness and grim determination that was typical of the rest of the hospital in its therapeutic activities. This was in no way the fault of the shop instructors, but the idea of a workshop was so new that it was difficult to convince some of those who saw it in operation that work therapy differed in no essential way from any other kind of treatment, and that it was just as direct and as

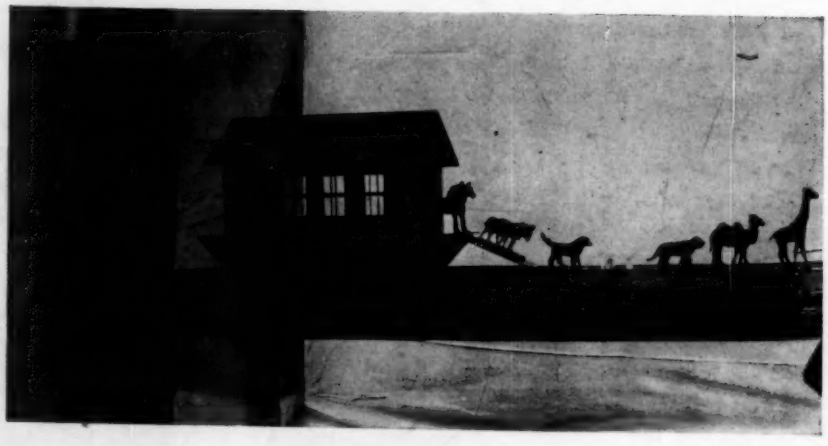
carefully planned to meet and combat a symptom as an orthopedic apparatus to correct a deformity. The civilian aids, all of them, soon acquired the correct idea, and they shared with other members of the hospital staff the purpose and aim of all treatment in this hospital, which was to cure the patient so that he might go back to his division and do his share in fighting the Germans. The insistence on the purpose of the hospital is emphasized because it is necessary to reduce to its simplest form both the problem and the measures for its solution, in order to appreciate and to measure what was accomplished. To get at the primary principles by this kind of observation permits of an extension of its utility under less difficult and more elastic surroundings.

In civilian hospitals there is no need to keep in mind the immediate task confronting a patient, and there is certainly no particular advantage in insisting that he return to the environment that caused him to be a patient. Quite the opposite may be the proper thing to do. On the other hand, the therapeutic aim must be kept in the foreground, and the patient must realize that occupation is primarily a method of cure, not a pastime and not a thing to which he can afford to be indifferent. It is necessary also that this idea be shared by the physician who prescribes work therapy and by the instructors who carry out the prescription. In the intermediate territory where vocational training and occupational therapy closely touch, the importance of this attitude is easily appreciated. A military hospital serves its chief purpose in returning a sick or wounded or neurosis patient to military duty. There is no choice and no alleviation to this hard necessity. The very thing and the very circumstances that caused the disability are precisely those to which the soldier must be sent back as soon as he is cured. In this way a military hospital plays its silent and unromantic part in the grim and ugly game of war.

In a civilian hospital an opportunity is given to make of the patient a better type of worker, a more efficient citizen, by modifications in his environment or by training him to do things in a better way. Perhaps it will be possible in some future development of the shop idea to add to his educational assets, to give him a broader outlook, to make him see the economic and industrial conflict from a broader point of view. The possibilities seem to be without limit, and they have been scarcely touched in our present hospital method.

All such impulses will be without avail unless the working out

A patient weaving



Toys made by officer patients

of the plan is filled with a spirit of incisiveness and with a definite conception of what the whole thing means, and is completely divorced from the amateur spirit and from the attitude of dilettanteism which it is so difficult to keep out of extra-medical therapeutics.

The experience at LaFauche has shown the possibilities of work therapy under difficult and adverse circumstances and in primitive conditions. It has proved the efficacy of this treatment as an adjunct to other methods in a material that is commonly regarded as difficult to treat and more difficult to restore to military duty. Under all sorts of tests and with all types of war neuroses, occupational therapy has shown its value. The testimony has been so convincing that no hospital in war or peace that pretends to treat neuroses can afford to be without its occupational workshop. There remains, then, to put into the treatment of the civilian neuroses something of the spirit that animated the nurses, the civilian aids, and the medical staff at Base Hospital 117. That spirit was made up of understanding, enthusiasm, and a definite conception of the purpose that placed the hospital in the foothills of the Vosges Mountains.

DISCIPLINARY PROBLEMS OF THE ARMY*

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IT has been for some time a well-recognized principle among public-welfare workers that delinquency and crime have certain aspects that make a psychiatric or psychopathological inquiry in each case almost a necessity. This work, which has been so firmly founded by the pioneer work in this country of Doctor William Healy, Doctor Goddard, Doctor Glueck, Doctor Guy G. Fernald, and others, has nevertheless not received the attention and the public assistance that are required to put it on a more permanent footing. In spite of the work that has been carried on in the juvenile courts of Chicago and Boston by Doctor Healy, and by Doctor Guy Fernald at Massachusetts State Reformatory, as well as that of the Psychiatric Clinic at Sing Sing under Doctor Glueck, such work is still regarded by many as somewhat of a luxury, though perhaps a desirable one, in penal institutions. It is very encouraging to know that this work belongs to a group of enterprises that in the ordinary times of peace have had a rough road, but that as a result of the emergency demands of the war are gradually coming into their own.

The military establishment of the United States could not ordinarily be considered a likely place in which to find important work of this sort being carried on. The popular conception of military discipline is such as to preclude much expectation of finding welfare work and personal service regarded as of sufficient importance to require special or elaborate arrangements. Nevertheless, the military establishment has not only given consideration to this important field, but has actually exceeded the rather modest requests of the workers.

I am fortunate in having had some personal acquaintance with the disciplinary work of the army and in having this opportunity to bring before the Conference some of the results of the work of the Neuropsychiatric Section of the Surgeon General's Office in

* Read as part of a symposium on Disciplinary Problems before the Mental Hygiene Section of the National Conference of Social Work, Atlantic City, June 7, 1919. The other papers in the symposium were *Mental Disease and Delinquency*, by Dr. V. V. Anderson, MENTAL HYGIENE, Vol. III, No. 2, pp. 177–198; and *Disciplinary Problems of the Navy*, which is published in this number.

connection with disciplinary cases. Under the far-sighted leadership of General Crowder, Judge Advocate General of the Army, a constructive program of development of the disciplinary service, beginning in 1909, has been put into effect. As a first step in this connection the name of the institution at Fort Leavenworth was changed from the Military Prison to the United States Disciplinary Barracks. This clearly indicates the policy adopted by General Crowder—that punishment and the infliction of suffering were to be replaced by training and education and attempts at rehabilitation, whether in the army or in the civil community.

In ordinary times the United States Disciplinary Barracks at Fort Leavenworth had about 1,700 prisoners; the Atlantic branch on Governors Island had about 250, with a capacity of about 500; the Pacific branch on Alcotta Island, San Francisco Harbor, contained about the same number as the Atlantic branch, with a capacity of 500. The Disciplinary Barracks at Fort Leavenworth are located on a large military reservation and have been developed into an industrial training school where some seventy-eight trades are taught. It is unnecessary to describe the Barracks at this time, as most of those present no doubt took the opportunity at last year's conference at Kansas City to visit the Disciplinary Barracks. They will remember the very beautiful farm, the active shops, the large and airy cell buildings, and the barracks and exhibition drill of the disciplinary battalion. They will recall that the main building of modern fire-proof construction was erected at a cost of a little over $700,000, entirely by prison labor, with a saving of almost $2,000,000 to the government.

Since the meeting at Kansas City, certain things have occurred at the Barracks which have been reported, with more or less bias for or against, in the newspapers, and which have caused welfare workers throughout the country to doubt whether the efficiency of the Barracks was all that it appeared to be or that had been claimed for it. It might, therefore, be of interest to detail some of the causes for this in the light of work that has been carried on at the Barracks during the troubled times just past.*

In the first place, it will cause no surprise among you when you are told that one of the first effects of the war upon the Disci-

*The opinions here expressed are the opinions of the writer on some controverted points and do not in any way represent the official opinions of the War Department.

plinary Barracks at Fort Leavenworth was the withdrawal of nearly all the competent officers and guards. The trained guards were replaced by limited-service men, mostly from neighboring cantonments, and, with the stopping of recruiting, it was impossible to secure help. It was with great difficulty that the commandant succeeded in retaining the services of a handful of trained, competent officers, in view of the great need for them on more active military duty. So great was the need for trained officers that even the large addition of reserve officers, among whom could be found numerous individuals of great value to this work, could not be drawn upon. To make the situation still more difficult, the expected increase in the number of prisoners soon began to become evident. Instead of a normal population of 1,700, there were, in July 1918, 2,400 prisoners; by December 1918 this had increased to 3,600; by February 1919 it almost touched the 4,000 mark. Even this, however, would not have produced insurmountable difficulties had the population been of the sort that the Barracks were designed for, but a situation was created which presented almost an insoluble problem when, in the course of a few months, a group of some 500 conscientious objectors of various sorts were concentrated at the Barracks as military prisoners.

It is not necessary here to go into the problem of the conscientious objector, or to take the time to discuss what might have been done, excepting in so far as the experience may have taught us what to do and what not to do in such or similar situations in the future. And by this we need not understand that these lessons apply only to the eventuality of another war. The problems and the difficulties in the disciplinary service of the United States Army are problems and difficulties that are with the community at all times—in peace or in war—and the methods that work in the one will work in the other.

The conscientious objectors, as is well known now as a result of the publicity that they have had, and especially as set forth in the book by Major Kellogg, represent a heterogeneous group of men. They had only one thing in common—namely, their resistance to the selective-service act and their unwillingness to bear arms. The reasons, the underlying motives, the previous experiences and training, the advantages or difficulties of each individual's career that lay back of the stand he took are almost as many as there are individuals in the group. With few excep-

tions, these men had committed no real delinquency, but were only technically law breakers. It is natural that their attitude towards confinement in a correctional institution should be quite different from that of the ordinary man sentenced there, who, however much he may extenuate his case, must have some realization of the reasonableness of his confinement. The second point of importance here was that in general this group was in education and intelligence equal to the average unit in the army or in the community and in numerous instances far superior. As a result there were among this group a number of very able leaders who, by skillful agitation and by perseverance, were able to coördinate the various motives and activities, not only of their own group, but of the prison population as a whole, with the result that soon the entire body of prisoners was in a sense organized for offensive and defensive purposes.

You have probably all read the report of the culmination of these tendencies and activities in the strike of last winter. This report, which was published in the *Survey*, was written by Mr. Winthrop D. Lane, who was present during the entire affair. Owing to the very far-sighted and fair attitude of the commandant, in which he had the support, not only of the competent officers of the Barracks, but also of the commanding officers of the post and of the infantry regiments stationed at Fort Leavenworth, this critical situation, fraught with all sorts of danger, not only to the institution, but perhaps even to the democracy of the country as a whole, was converted into a distinct gain in prison management. Representative government was reëstablished after a discontinuance of some years at the Barracks and under conditions which had the appearance of making it impossible under military law in time of war.

Crude as is this beginning at a coöperative management of penal and correctional institutions, it has been, on the whole, eminently successful and is still functioning with benefit to the prisoners and the institution alike, in spite of many recurring obstacles which are thrown in its way by hasty and injudicious acts on the part of uniformed officers without sufficient previous experience and training in this work.

The one thing which has contributed more than any other, perhaps, to the prevention of the more serious dangers and difficulties, and which offers most hope for the future, has been the work of the neuropsychiatric officers in connection with this

institution. With all due allowance for mistakes and lack of skill, which are evident in the work of some of these officers, it can yet be maintained that had there been no department of psychiatry and neurology at the Disciplinary Barracks, and had the system originally devised by Colonel Rice and Lieutenant Colonel Edgar King, and greatly developed as a result of the constructive leadership of Colonel Pearce Bailey and the Neuropsychiatric Section of the Surgeon General's Office, not been so firmly established, the results might have been far otherwise than they turned out to be and might even have ended in real disaster.

At the United States Disciplinary Barracks the work of the neuropsychiatric department is not confined, as it has been in some of the civil institutions where it has been used, to the detection of gross mental abnormality. On the contrary, it has been coördinated with every activity in the Barracks. Each prisoner is regarded as an individual human being, and a personality survey is essential before any program is outlined for the prisoner. At every change that is made in his treatment, whether it is the granting of privileges, transfer to other living conditions, employment, education, release, reinstatement in the army, the neuropsychiatric officers are first called upon to examine into the facts and to make recommendations based upon the tendencies and the requirements of the individual prisoner. Many mistakes have been made in this, and as a result, no doubt, justice has not always been meted out; but taken as a whole the work of these officers has justified itself in view of the fact that the Barracks have been able somehow to weather the storm of the war and all the bad conditions suggested above.

In the course of last winter, a special survey of the institution was made as part of the training course given to psychiatric officers in disciplinary work under the direction of the Neuropsychiatric Section of the Surgeon General's Office. The results of this survey are of some interest in connection with the penal and correctional problem as a whole.

Before speaking of these results, it may be well to know that, large as was the prison population, it was very much smaller than was anticipated. At the outbreak of the war, the commandant, in reply to a request from Washington, made an estimate based on the figures for the Civil War, for the Spanish-American War, and for the operations on the Mexican Border, as a result of which he reported that an army of 3,000,000 men would require provi-

sion for about 50,000 prisoners at the Disciplinary Barracks. Instead of 50,000, the Disciplinary Barracks, including the two branches, received about 5,000 prisoners—in other words, 10 per cent of the estimated number based on previous experiences.

This can be explained on only two grounds: first, the enforcement of prohibition in the army in general and especially in cantonments and their neighborhood; second, the elimination, through the work of the neuropsychiatric officers, of low-grade defectives, insane, and psychopathic men at cantonments and recruiting stations. It was not very astonishing, therefore, to find, when the survey was made, that the distribution of intelligence among the prisoners examined, which included about 3,500 men, was practically that of the ordinary division of troops. There was an absence of the high proportion of defectives and psychopaths found in nearly all of our civil prisons. Instead of the 30 or 40 per cent of feebleminded and psychopaths found in the latter institutions, between 10 and 12 per cent were found among the prison population at Fort Leavenworth.

It was found that there was a correlation between education and intelligence. The educational median of the entire group fell in the seventh grammar-school grade. The men in the disciplinary battalion were, on the whole, rated higher both in intelligence and education than the general average. The religious and political conscientious objectors were the best educated of all the prisoners and had the highest intelligence rating. The men convicted of sex crimes and crimes of violence had less education than most of the other groups and were rated lower in intelligence. The men convicted of acquisitive crimes had more education than the average and a higher intelligence rating than any other group except the religious and political conscientious objectors. The conscientious objectors of the alien-enemy and non-citizen group were very low as to education and intelligence rating; a third had no schooling at all and half of them did not get beyond the third grade.

An analysis of the personality reactions of the prisoners was made, dividing the prisoners according to their findings into three general groups: (1) those who had been in difficulty as a result of lack of intelligence or judgment or because of some other marked mental defect; (2) those who showed no decisive defect, but whose difficulties, either in the army or previously, could be traced back to emotional instability either in the direction of violent

temper or loss of control or of discouragement and depression; (3) those whose difficulties could be traced to a marked egocentric characteristic or trait.

With the cases classified in this way, it was found that 66 per cent of them fell into the egocentric group, 24 per cent into the inadequate group, and 6 per cent into the emotionally unstable group. The small number of the emotionally unstable group can be explained by the fact that as a rule delinquents of this sort arouse the sympathy of their fellow men, and the experience of the Disciplinary Barracks corresponds to that of civil institutions to the effect that these individuals are rarely sentenced to confinement, but are released at some point in the chain of events previous to commitment.

The inadequate group includes the feebleminded and low-grade cases that had passed through the elimination of the neuropsychiatric officers at camps or had been sentenced before the neuropsychiatric work had become established. With the elimination or reduction in numbers of the insane or feebleminded cases, there remained the large group of egocentric individuals who probably represent the principal part of what may be justly termed the penal problem. The egocentric type of person, who is rather intolerant and set on his own point of view, insistent on his rights, ready to be offended and injured and always uncompromising, may be associated with any other ability or disability that the human personality is capable of. The group includes not only every sort of delinquency recorded at the Barracks, but also a large proportion of the higher-grade conscientious objectors.

No attempt is made by the neuropsychiatric officer to pass on the social value of this type of personality. It must be obvious to every one that the egocentric trend in itself is not an undesirable feature—that in many instances it is nothing more than another name for what we ordinarily term ambition. Furthermore, none of the characteristics or traits that have been used in this classification appear in themselves as abnormal manifestations or as isolated traits. Probably every one is defective, emotionally unstable, and egocentric in varying combinations. No attempt, therefore, was made to apply a twelve-inch rule of analysis to human personality in general. It is important to note that this classification was confined to an analysis of the difficulties that the individuals concerned had experienced in their environ-

ment, including not only their military experience, but, so far as was obtainable, their whole record; that no attempt was made to determine whether an individual was emotionally unstable, egocentric, or defective in general, but only to explain as far as possible the difficulties experienced by him in the course of his life on the basis of one of these general characteristics or reaction types. As a result, one might set up a perfect scale in each classification of cases, with extreme manifestations at the lower end graduating at the upper end into cases that are hardly distinguishable from successful and eminently satisfactory individuals.

Each individual human being has his threshold value, his breaking point at which the balance between him and his social environment may be upset. When it is upset, however, the inherent personality will manifest itself and the reaction will be more or less consistent with his make-up. It is not for us to say in every case whether the individual was justified in his reaction or not. In many cases time alone will tell whether the egocentric trait, for instance, which manifested itself in an uncompromising adherence to the course of conduct once determined upon was desirable or not. Many a feebleminded person, many an eccentric, psychopathic individual, even in some cases an insane person, has contributed to the world's welfare; nor does the element of personal sacrifice or suffering form any decisive guide in this respect.

We cannot undertake to deal with this phase of the problem. For those of us who are approaching this subject from the point of view of the psychopathologist it is sufficient to give an explanation and not to attempt an evaluation. With the advantages that the army has had in the elimination of the unfit physically and mentally, such as is never possible in civil practice, it must be apparent that one of the principal problems of the correctional and penal field, if not of sociology as a whole, is the problem of what we have here termed the egocentric personality which so frequently manifests itself as the insubordinate personality.

It is not necessary in the face of these statements, however, to be fatalistic or pessimistic about this subject, for even though we may not at present be able to influence to any great extent the underlying personality and mental make-up of those who are placed under our care as a result of social difficulties, a great deal can be accomplished in producing an adjustment between the individual—whatever his peculiarities and however fixed these

peculiarities may be—and his social environment. Even under the difficult conditions at the Disciplinary Barracks, it was easy to demonstrate that by a wise analysis of the difficulties, both on the personality side and on the environmental side, and by a recognition of the intellectual abilities and disabilities of each individual, such an adjustment could be effected; and that it was perfectly possible to maintain order and secure coöperation on the part of the prisoners, no matter which personality group or which classification of delinquency or behavior they belonged to.

That seems to me to be the contribution of the disciplinary service of the army to all welfare work. It may be summed up in this statement: the solution of the behavior problems of the individual depends upon as accurate as possible a knowledge both of the individual and of his environment; this knowledge can be obtained by the mental studies of the neuropsychiatric officer and the social investigations of the social worker, and their findings may be combined into a constructive therapeutic program which will ultimately, and often rapidly, reinstate the individual in the community as a safe and self-supporting citizen. While this program is more difficult in the case of the low-grade defective, even there it is more hopeful than is generally believed and is economically advantageous in all but perhaps the most extreme cases of feeblemindedness and insanity.

DISCIPLINARY PROBLEMS OF THE NAVY*

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THE problem of discipline in any military service is always one worthy of the deepest thought and consideration, and one which is far from being solved to the satisfaction of all its students. Some authorities approach the matter with only one object in view, the production of the maximum deterrent effect upon the mass; while others think upon the problem in terms of effect upon the individual in order to prevent a repetition of the same offense in that individual. There are officers in the navy who favor the maximum amount of punishment for every offense with the idea in mind of preventing the offense in others, and without consideration for the individual at court.

They believe that, generally speaking, the heavier the sentence, the less the likelihood of that offense being committed by other men. This policy is probably the easiest of application because it requires no large amount of deliberation as to sentence if the accused is found guilty, as he is given the maximum sentence allowed by law.

Other officers believe that each case is worthy of study from all angles before a sentence is imposed, in order that justice to the individual may be done. This policy is one usually well tempered with mercy; as a result each case requires more time and effort than when the first policy is followed. For the most part, the officers who believe in the second policy are actuated largely by humanitarian motives and they believe that the military does not suffer from the mixture of the humanitarian.

In the navy during the pre-war period, the problem of discipline was of relatively small magnitude, because of the relatively small size of the navy. But when the United States entered the war, the navy jumped in numbers of men tenfold, almost overnight. With this great increase in the enlisted personnel there was to be expected a like increase in the navy's prison population. On April 1, 1917, there were 268 general court-martial prisoners under sentence at Portsmouth. This number increased, by leaps and bounds, until August 1918, when the high water mark of 2,517

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was reached. The monthly admissions were highest in February 1918, when 376 new men were admitted to the Naval Prison. The prison was built to accommodate between 300 and 350 men, so that temporary buildings had to be constructed to care for the rapidly increased admission, but it was months before these new buildings could take adequate care of the housing situation. A policy of restoration to duty of large numbers of men serving sentences for the so-called military offenses, after a portion of their time had been served, was instituted with the result that much relief was obtained by that means.

Some idea of the types of men who constitute the population of the Naval Prison may be conveyed by saying that, of 1,895 admissions, 45 per cent are not over 21 years old, 76 per cent are not over 25, and 92 per cent are not over 30 years of age. Sixty per cent of them said they had reached the eighth grade in school; and 5 per cent of them had completed high school. From an occupational standpoint, at least 75 per cent of them belong to the class of unskilled labor. About 25 per cent of these 1,895 admissions acknowledge a court record prior to enlistment. Of the cases studied more intensively we have found about 50 per cent have resided at some previous time in a penal or insane institution.

A word should be said about the character of offenses for which men are committed to the Naval Prison. The list ranges from murder to drunkenness, and the sentences vary in length from life to three months. The majority of admissions are for desertion, absence over-leave, and absence without-leave. It is very difficult to say accurately just what percentage of the men are serving sentences for purely military offenses, but it is probable that about two-thirds of the offenses are of a military rather than moral character. However, the offense is of very little significance, except in a small proportion of the cases, in determining the diagnosis or prognosis in any given case, so far as social usefulness is concerned. In fact, the offense is often a very misleading bit of information upon which to judge a given case. I have in mind one man who came to the Naval Prison guilty of absence over-leave a few days who had, only a day prior to his enlistment, been discharged from a state prison where he had served a sentence for rape.

Organized psychiatric examinations of general court-martial prisoners were begun about November 1, 1917. Before that time interest in the psychiatric problems of general court-martial prisoners of the navy was only scattered and little organized

effort was made to study the problem. In 1914 Passed Assistant Surgeon G. E. Thomas, U. S. Navy, at that time medical officer of the prison, undertook psychologic examinations of the men as they were admitted to the prison, together with the physical examination upon admissions, but I am told that he was able to accomplish little in the way of altering the course of any given case of mental abnormality, so far as a man's sentence was concerned.

When I was detailed to psychiatric work in the Naval Prison the lack of trained help and the lack of a place to work, because of the tremendous overcrowding, were very serious difficulties. It was not deemed advisable then to undertake a more or less superficial survey of the whole mass of prisoners because there appeared to be so many cases which had already attracted the attention of the prison authorities to their mental condition. An untrained yeoman was assigned to help me and we started by making complete examinations of cases referred by the officials of the prison. A full history of each patient was taken and where possible statements as to previous residence in penal or insane institutions were corroborated by correspondence. Each patient was examined psychologically and neurologically, and in some cases a period of observation was used in the Naval Hospital before arriving at our conclusions.

We began to find that about two-thirds of those examined showed evidence of disorder or defect at the central nervous system level. Then the problem of what to do with these cases arose; as a result in February 1918 a series of recommendations were made to the Navy Department, chief amongst which was the request for the construction of a psychopathic ward in connection with the Naval Hospital for the observation and study of cases. This request was approved with the result that now there is a psychopathic pavilion of two buildings completely equipped for the accommodation of 50 patients as a separate ward of the Naval Hospital. This ward may serve the enlisted men who are not prisoners as well as the general court-martial prisoners. There are now assigned to the work two medical officers, three yeomen, who have become fairly proficient in the taking of histories and giving the intelligence measure, two state hospital trained nurses, and eight hospital corpsmen, who are especially trained in handling psychopathic patients.

Since August 1917, the Naval Prison has been under the command of Lieutenant-Commander Thomas Mott Osborne, who

introduced the Mutual Welfare League there for the self-government of the prisoners. Hence the conditions of living for the prisoners have been less exacting than under a strictly military régime, and there is less need for repression amongst the prisoners than in a strictly military environment. Free expression of individual characteristics, both good and bad, is possible. This factor, I believe, makes the psychological study not only less difficult but permits of reaching more accurate conclusions than is possible under what we commonly think of as the prison environment. Whenever a case is studied, a report of the diagnosis and recommendations, if any, is made to the Commanding Officer. These reports are intended for his guidance in dealing with that particular case. A report is also made in the man's Health Record, which is his medical department record in the service and follows him from his enlistment until his discharge from the navy.

A short interview is held with every man when he is admitted to the prison, and again when he is discharged from the prison. Upon admission, data are obtained concerning his age, civil condition, offense, length of time in the navy, arrests, diseases, habits, education, occupations, and any complaints he has to offer; he is then graded, arbitrarily, on a scale of four, as to his fitness for the navy. Upon release from the prison a note is made as to his conduct record while in the prison, his statement as to the benefit he has received in the prison, any complaints he has to offer and his intensions as to his future. These data are meager and only serve as a starting point from which cases are selected for complete examination.

During the period of nearly two years that this work has been carried on, we have made complete examinations of about 800 prisoners, and we have interviewed about 2,000. We have discharged from the service, by recommendation of a Board of Medical Survey for nervous or mental disorders, 108 general court-martial prisoners, and have transferred by the same means to St. Elizabeths Hospital Washington, D. C., 26 cases. There is, quite naturally, some reluctance on the part of the naval authorities in discharging certain prisoners before the expiration of their sentences because of mental abnormality, and there is always longer delay in obtaining authority for the discharge of a prisoner for medical reasons, than in the case of enlisted men who are not prisoners. However, an order from the Secretary of the Navy, in June 1918, directed that all prisoners, not physically or mentally

fit for the service, be brought before a Board of Medical Survey for recommendation.

There has been a lack of uniformity in the psychiatric work at the various Naval Training Stations, but I believe that at most of the stations the psychiatrist has eliminated from the service army offenders, who otherwise would have gone on to the prison through the regular channels. Unfortunately, not all have been diverted away from the prison, who might better have gone elsewhere. Aboard ship where trained help is not available it is usual for an offender to be disposed of by a sentence rather than through medical channels.

In the navy when a man is convicted by a general court-martial, he is "read off" as the blue jacket says. That means that his finding and sentence are read aloud, in his presence, before the whole of the ship's company. This, undoubtedly, has a very definite deterrent effect, but just how much, no one, I believe, is able to say. It is not the successful preventative that we might wish. During the war, especially the first months of the war, the sentences administered were longer, for the same offenses, than had been given in peace time, and general courts-martial were given for offenses previously punished in other ways. So far as we were able to observe in the prison the increased sentences added very little to the deterrent effect, if any at all, and certainly not in proportion to the increase in the length of sentences.

The psychiatric approach paves the way, in my opinion, to a less expensive method of handling the problem of military delinquency. If the navy is regarded as a large organization, with a definite function to accomplish, then it behooves us to conserve the usefulness of the members of the organization as far as possible, for the benefit of the navy, and eliminate those who are a constant expense. From the cases we have studied we find that about 50 per cent of them are men of whom it was easily demonstrable that they were either nervously or mentally not fit for the service, and as two-thirds of our cases are men who find themselves in the Naval Prison less than one year from the date of their enlistment, it is reasonable to suppose that these men were also unfit when they enlisted. Therefore, the best single point of attack to the navy's prison problem is at the recruiting office, and it falls upon the shoulders of the medical officer.

Unfortunately, our state of knowledge is not so perfect that we can eliminate delinquents at the recruiting station by means of a

yard stick or other instrument of precision, but the taking of a short social and medical history at the recruiting station will eliminate most of the undesirable types. I hope to see more responsibility put upon the recruiting medical officer in this regard. This may be done by keeping him informed as to the disposition of his recruits, and by rating the efficiency of a recruiting officer by the number of useful men he enlists, rather than by the number of men of all sorts.

It is gratifying to see the active interest displayed by the medical corps in the possibilities of prevention of military delinquency, and I am sure that the results of this interest, which we are beginning to see, will serve to deepen it.

THE FUNCTION OF THE SOCIAL WORKER IN RELATION TO THE STATE HOSPITAL PHYSICIAN*

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IT is probably quite unnecessary to emphasize so strongly as I propose to do the need for close coöperation and careful delimitation of function between social worker and physician but this relationship is of such fundamental importance that I offer no apology for doing so. Social workers, in my experience, are usually anxious to consult, and are fully conscious of the difficulties they experience when the physician fails to take his proper place, a failure which is on his part largely due to diffidence resulting from lack of training. But I think we will all agree that it is just as much an error for the social worker to take charge of a case and call in the physician only when she meets with difficulties as it would be for the nurse in a hospital. It is the function of the physician to make the diagnosis and to prescribe the treatment to be followed, leaving to the technician, be she nurse or social worker, the technique of its execution.

At the last meeting of the National Conference of Social Work I presented a specific plan for the organization of a state hospital for the treatment of the patient while within its walls. This present article must be considered as a corollary to that plan, which endeavored to emphasize in a practical way the preparation of the patient for return to social life.

In discussing the relations between the social worker and the state hospital physician it is necessary to consider the duties of, and the problems which confront, the latter. These have, in recent years, undergone large expansion which is partly expressed by the growing recognition of the need for the employment of social workers.

*Read as part of a symposium on Psychiatric Social Work before the Mental Hygiene section of the National Conference of Social Work, Atlantic City, June 1–8, 1919. Other papers in this symposium, by Dr. George Kline, Miss Margherita Ryther, and Miss V. May Macdonald, are published in this issue. For papers by Dr. C. Macfie Campbell, Dr. Bernard Glueck, Dr. Edith R. Spaulding, Dr. E. E. Southard, Dr. Jessie Taft, Prof. William H. Burnham, cf. MENTAL HYGIENE, July, 1919; Miss Mary C. Jarrett, MENTAL HYGIENE, April, 1919.

Physicians in general are beginning to realize that their duties are far broader than the mere treatment of disease and that they must include the treatment of the patient as a man. This implies a study of him not merely as an individual composed of a number of organs each of which is liable to structural disease or damage but still more as a unit of a social organization in which he must so behave as not to menace his relation with, and the welfare of, the group of which he is a member.

While this statement is generally true for all medical work, it is quite specially true for that large group of disabilities which fall under the head of mental disorders. For while the welfare of the individual depends primarily upon the health and proper functioning of the organs which compose his body, his successful adjustment to social life and the welfare of the social group itself depend upon his behavior, which is the use he makes of the bodily organs with which he is provided. Social behavior is nothing but the proper regulation of body activities and is rendered possible by the activity of the brain, which is the mind.

Disorders of the mind are thus essentially disorders in behavior and of necessity imply greater or less social discord. Even serious bodily handicaps do not necessarily preclude a social adaptation, but mental disorder means that the individual is more or less extra-social and sometimes actively antisocial. The science of mental disorders, or psychiatry, deals therefore essentially with social problems and conversely one is justified in stating that there is a psychiatric element in all social work. Dependency, delinquency and insanity may, it is true, be the result of bodily disease or defect and be therefore medical in the more narrow interpretation of that term but in so far as these conditions are social problems they are psychiatric and the physician is concerned not only with the problem of restoring the individual to health but also with establishing a type of behavior compatible with the handicaps present and the requirements of social existence. The recognition of this psychiatric or mental element in social work is, I believe, of fundamental importance if we are to avoid in this field the errors of omission which have so long lowered the efficiency of medical practice.

The state hospital physician is primarily a psychiatrist, his special field being that particular group of mental disorders classed under the heading of insanity. The sole reason for the admission of patients to state hospitals is the disorder of conduct

which renders them incapable of social existence. A paretic, for instance, is not sent to a state hospital because he has syphilis of the brain but because his conduct either already has been, or is liable to become, such as to render him a menace to himself or others. It is therefore somewhat astonishing to find that it is only now that we are beginning to appreciate the importance of employing social workers in connection with state hospitals. Like the general hospital, the state hospital has concerned itself with the treatment of the patient merely as an individual suffering from some "disease" obscure though this most often is admitted to be.

Many persons are even yet unwilling to recognize that insanity at times may not be associated with disease at all but be merely a mode of reaction to the conditions under which the particular individual, with whatever handicaps as to structure he may have, finds himself, and thus be a social problem almost purely, the remedies for which must lie in the modification of the conditions to be faced and the training of the individual to better methods of meeting them.

The majority of state hospitals even today are concerned only with the care of the person insane and content themselves in their anamnestic study of the patient with a history of the bodily diseases and defects which have preceded the onset of the insanity. Should no disease capable of remedy be discovered the treatment is liable to become purely custodial. Under the simplified conditions of life which obtain in the hospital the patient often improves very materially and may sooner or later be considered fit for release. He is liable then to be permitted to return to conditions more or less the same as those under which he broke down before. Often, it is true, he has suffered a definite lowering of mental capability which, while it may possibly render the danger of actively unsocial conduct less, must nevertheless render the probability of dependency far greater. Such persons are much in the position of the old-time handicapped soldier. His wounds had healed under surgical treatment but he had lost a limb or become otherwise crippled and only too often he remained more or less helpless and dependent upon charity or descended to peddling shoe-strings for a living.

To guard against a repetition of this state of affairs our present government has wisely decided to establish machinery, necessarily somewhat elaborate, which provides not only for the best possible medical and surgical treatment of the damaged parts of the body,

designed to restore them to the greatest possible degree of usefulness (this corresponding with the view most usually adopted of the function of the state hospital) but which will in addition aid the study of possibilities in the way of useful employment and placing of handicapped men and the training of these men for work which they can adequately perform and in which they can successfully compete with their more fortunate fellows.

The problems before the state hospitals are essentially the same, varying only because of the kind of disability. This difference, however, renders the study of the patient alone often quite insufficient for the definition of the causes, and hence the proper treatment, of the breakdown from which the patient is suffering. These are often extremely complex and may be compounded of disease and its consequences or defect of the patient's body *ab initio* with difficulties of social adjustment. Of these latter the patient can often tell little or nothing and it becomes necessary to discover the facts by a study of the environment in which the disorder developed. This environment includes not only the patient's home and relatives but also the conditions and associates of his work and play.

The investigation of these conditions is an important function of the state hospital social worker. To carry them out requires some knowledge of the symptoms of mental disorders and their relation to social adjustment, in other words a psychiatric training. While much of the information to be collected may be more or less routine, it is essential that it be selected in the light of the needs of the individual case. For this reason there must be close coöperation and consultation between the physician and the social worker, for it is only the former who, by reason of his psychiatric knowledge and study of the patient, can specify the needs.

In the course of the studies of the patient himself by the physician and of the environment from which he comes by the social worker, it may well happen that conditions are discovered which have a direct influence upon the immediate happiness or distress of the patient, such as the dependency of his family upon relief, etc., or which may be of importance to society for the prevention of later difficulties such as syphilis or of some other condition which might lead to the breakdown of other members of the family. These it will of course be the function of the social worker to deal with either directly or by reference to other special agencies devoted to such needs.

Upon the results of the study of the patient combined with the facts elicited by the social worker concerning conditions which have prevailed prior to the onset of, and which perhaps have precipitated or even caused, the disorder in behavior which was the occasion for commitment of the patient, must be based the prescription of treatment. It cannot be too strongly emphasized that this must be purposefully designed to fit this particular patient for the resumption of social life under conditions which offer a probability of success, and I believe that much is to be gained by laying down, quite early in the period of the patient's residence at the hospital, the specific conditions which must be fulfilled before release can be considered.

Part of these conditions quite frequently concerns the outside environment of the patient fully as much as it does the patient himself. Treatment applied to the social surroundings such as readjustment of home, work and play conditions, the settlement of family and neighborhood conflicts, prejudices or misunderstandings, the education of relatives and others as to their attitude towards the patient, etc., may be as important factors in determining the return of the patient to a social existence as the training of the patient himself. Such treatment should not be left until it is time for the patient to leave but should be initiated at the earliest possible moment after he enters the hospital.

The execution of this program is quite obviously work for the trained social worker, requiring a high degree of tact and skill combined with a knowledge of the possibilities afforded by communities in various localities. Here again it is evident that the very closest coöperation between physician and social worker is essential in order that unnecessary meddling and unwise changes may be avoided. The function of the physician is to make a diagnosis by giving due weight to all available facts and upon this basis to prescribe the remedies. The task of finding the way to accomplish the ends prescribed in so far as they concern the relation of the patient to the social world is the function of the social worker. Obviously these results can be materially favored by requiring the social worker to be present at staff meetings where the treatment of the patient is discussed.* To gain any-

* As a digressive corollary I might add that it would be well to have the responsible nurse and other therapists who will have charge of the treatment of the patient himself while in the hospital also present at these discussions so that all may work together more intelligently. The social worker, it is true, must of necessity work less under the direct supervision of the physician than the nurse and it is hence imperative that she be fully cognizant of the results desired and the reasons for their prescription.

thing of value from such discussions she must be familiar with psychiatric terms and the significance of behavior types.

Thus far we have considered only the functions of the state hospital as they have largely been limited in the past. Its duties did not begin until the disorder was so fully developed that commitment was necessary and too often it ceased to concern itself with the patient after he left the hospital. Today it is realized that the state is to a great degree vitally concerned with the prevention of the need for commitment and with the after-care of patients when released. Since this means the study and treatment of persons living in society it is obvious that this field is especially one in which the social worker is a prime essential.

To be successful in any degree this work must be given the same careful consideration as to diagnosis and treatment as that given to the patient at the time of commitment, and hence again there must be the same close relation between social worker and physician. Let us consider first the question of after-care, which is so obviously a part of the function of the state hospital that it is difficult to understand why it has been so much neglected.

If the plan already outlined as part of the treatment of the patient be followed, (i. e., modifying unfavorable conditions in the environment as early as possible after commitment, combined with purposeful training of the patient himself in habits of occupation and recreation within the hospital, with his limitations, handicaps and the surroundings to which he is to be released kept in mind) there is established a definite criterion as to the conditions for release and this becomes part of a carefully planned line of treatment.

But, however carefully approached, this release must of necessity represent a more or less abrupt transition which needs the most careful supervision if it is not to result in failure. It is necessary that the social worker who is to maintain this supervision be thoroughly familiar with the patient, his difficulties and disabilities, with the general plan of therapy which has been, and is to be, followed, and also with the environment into which the patient is going; she must be furnished information concerning the possibilities as regards special dangers to be avoided and difficulties to be met which can be given only by the physician. Provision must be made for reports at suitable intervals as to progress, for consultations upon desirable modifications or changes in the treatment prescribed and for interviews

between patient and physician as occasion, foreseen or unforeseen, arises.

All these considerations must be made the subject of definite prescription which should be given by the physician in writing. The reports of the social worker as to methods employed and results achieved must also be written. Only so can we ever secure data upon which can be founded a better and more rational treatment of mental disorders of this type.

If such a system is adopted and honestly followed there is plenty of evidence to show that many persons now considered as doomed to life-long residence in a hospital can be restored to productive activity in a more or less restricted social environment.

During the war, when labor was scarce, we made the experiment in one of the Illinois hospitals of permitting a number of patients from the custodial, or as I would prefer to group them industrial, wards, to work in a neighboring factory where the management offered intelligent and sympathetic coöperation. The patients continued to reside in the hospital but worked in various departments of the factory at a full wage. The working conditions and the patients themselves were under the supervision of a social worker. The experiment was eminently successful and was entirely satisfactory to the employer, who asserted that he had never had more efficient help.

Unfortunately, with the signing of the armistice and the release of many workers from war activities, the labor unions objected, with some justice, that the competition was unfair, as the patients were still inmates of the hospital and received maintenance from the state. As a consequence, those who could not be released altogether had to be withdrawn. A practical solution of this difficulty may possibly be found by establishing, under the supervision of social workers, community houses in which such patients may live and be entirely self-supporting. It will require, however, the intelligent coöperation of both employers and labor organizations.

Finally we may consider briefly the function of the social worker in relation to the state hospital physician in connection with the problems of prevention. The interest of the social worker in this field is self-evident. That it equally belongs to the state hospital needs but little argument. The exact relationship between hospitals and preventive work is largely a question of organization, but the physicians of these hospitals are

practically alone in having an opportunity for psychiatric training.

In some manner, which may be varied to suit local conditions, it is necessary to provide clinics outside the parent hospital as close to the community as possible. These will be of value also in providing for after-care. To these clinics can be brought for examination and advice any persons who show indications of the danger of a failure to meet requirements. It will be the function of the social worker to establish communications between these clinics and the communities and to supervise and manage such treatment as is recommended. The relation of the social worker to the community is to be discussed in another paper and hence will not be considered here.

It is however essential to realize that successful prevention depends upon the anticipation of actual breakdown and that the social worker must be prepared to assist in giving instruction to the community as to the importance of such manifestations and the need for expert advice. The possibilities from these activities have been well demonstrated by the psychiatric work of the army physicians who established communications with prospective patients through line officers and non-commissioned officers who thus served in the capacity of social workers.

In concluding it may be pointed out further that the field of social service outlined here for the state hospitals exists equally in other forms of mental disorder or social maladjustment, including dependency, delinquency and crime. Just as with insanity, though disease and defect may enter into their causation, the real reason for social interference is conduct disorder, and hence they belong in the province of the psychiatrist for diagnosis and treatment just as does insanity. The problems to be met, though different in detail, are still essentially the same, and the functions of the social worker, as an aid to diagnosis, social rehabilitation, prevention and after-care, are identical.

SUMMARY

The social worker is a technician trained in the means for social adjustment and their application who, in relation to the state hospital physician, will have the following general functions:

1. To collect information of social conditions which existed prior to commitment and thus permit the establishment of rational diagnosis and treatment;

2. To apply to the social environment such measures as will be calculated to relieve worry and apprehension on the part of the patient, to prevent further breakdowns in the family and to prepare the way for the release of the patient;

3. To supervise the rehabilitation of the patient in society by assisting him in his relations with others, finding suitable occupation and recreation, and affording means of communication between physician and patient;

4. To establish relations between the state hospital physician and those who are in need of assistance by reason of habits of behavior which threaten danger of disharmony with society;

5. To carry out the treatment prescribed by the physician with a view to prevention of actual breakdown and commitment.

THE FUNCTION OF THE SOCIAL WORKER IN RELATION TO A STATE PROGRAM*

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DURING the last few years, state institutions have been increasingly broadening the scope of their activities and endeavoring to serve the community as well as improving methods of care and treatment within the institution. To this end the establishment of social service departments in the institutions caring for the mentally sick has played a very important rôle, it being recognized that social factors have a very definite bearing upon mental diseases,—their causes, treatment and prevention.

Before analyzing the relationship of social work to a state program, it may be interesting to note the development of methods used since early days and the laws and customs pertaining to the care of the insane in the United States. One may thereby gain a deeper insight into the functioning of social service in connection with a state policy as regards care of mental patients.

The right to deprive an insane person of his liberty existed in England under the Common Law which was transferred to the colonies of America. It was regarded as justifiable to "confine, bind and beat in such manner as might be required under existing circumstances." Care by relatives consisted mainly in confining in cells, pens and cages in most unhealthy conditions. The policy was that of economy.

In colonial times there was no machinery to enable the state to carry out its obligations to the dependent classes; therefore very few references are made to the dependent insane. In New England the care of the insane devolved upon townships or city councils and came to notice only when they needed charitable assistance. The dependent insane were classed as paupers—the first known settlement law was in 1639. The earliest legislation in Massachusetts was in 1676 which delegated the care of the insane to the selectmen and overseers of the poor. In 1736 this power was transferred to the judges whose action was largely based upon the opinions of the overseers and selectmen. A law was passed in 1715 requiring near relatives to provide for insane mem-

* Read before the Mental Hygiene Section, National Conference of Social Work, Atlantic City, June 6, 1919.

bers of their families; if they neglected to do so, a fine of 20 shillings was imposed upon them—the money being used for the dependent insane. Amendments to this law soon followed which were directed to the protection of the patients' property rather than to his personal comfort and safety.

In 1727 "disorderly persons" had become so numerous that a colony workhouse was built to which *all* disturbers of the public peace were committed regardless of their mental condition. A little later another law was passed to confine such "disorderly persons" in county jails—but in 1797 this section of the law was revoked. So far as known between the years 1793 and 1824, there was no public place in which harmless insane persons, not criminal, could be confined. In 1824 a law was passed whereby any person could complain to one of the civil authorities if he found an insane person at large. If no action was taken in 3 days, a justice of the peace could confine such a person, providing that adequate proof of his insanity could be produced.

According to Mosher, the first statute in existence regarding the insane is an act passed in 1788 under the title, *An Act Apprehending and Punishing Disorderly Persons.* This Act provided:—"Whereas there are persons who, by lunacy or otherwise, are furiously mad and so disordered in their senses as to be dangerous to go abroad, it shall be lawful for two or more justices of the peace to cause to be apprehended and kept safely locked up, such persons in some secure place, and, if necessary, to be chained there if their legal settlement be in the city or town of that county."

Some of the earlier records describe very closely the terrible conditions under which the imprisoned insane existed. The cells were literally dark dungeons—planks and straw were used as beds—inmates were clothed in filthy rags and were hardly recognizable as human beings. Air and light, if any, were admitted by means of 2½ foot window-openings into the prison. Frequently these persons were found in cellars whose windows were so in disrepair that snow and rain often fell upon the inmates and "there were times when it was difficult to keep them from freezing." Heat and cold were never tempered in these cells. It was not until 1827 that an Act was passed providing that—"A lunatic shall not be confined in any prison, jail or House of Correction in the same room with a person charged with a criminal offense."

Prior to the 19th century, care of the insane in America was largely a local matter and was entirely custodial. There are no

records in England, Europe or America to the contrary. The purpose of confinement was for safe keeping and was accomplished in ill-ventilated and inconvenient cells or pens in the basements of hospitals and other places. This was the only care that the medical profession and the public deemed necessary for this most wretched class of human beings. It is a well known fact that in many states, notably in New England, the contract for the pauper insane was awarded annually to the lowest bidder—not due to the fact that they were less considered than other dependents—it was the custom thus to make provision for dependents. In Connecticut, Massachusetts and New Hampshire, the insane poor, being classed as paupers, were annually sold at auction to those who were willing to care for undesirable persons for a money consideration. If families were not available or the person was dangerous or untidy, he was placed in a jail or strong pen in the care of relatives.

It is interesting to note that such treatment and the resulting conditions naturally appealed to philanthropic and benevolent people and many private donations were made for better care in private hospitals. The Pennsylvania Hospital Department for the Insane thus developed into the present institution; the insane department of the New York Hospital thus became the present Bloomingdale Hospital; the McLean Hospital of Boston performed a similar service until the establishment of the Worcester State Hospital.

In passing it is well to note that county care of the insane originated only as an emergency, when no suitable provision could be found elsewhere and county jails were simply an emergency provision. Nearly every state has a history of county care. The necessity of providing for chronic cases led several large cities—Boston, New York, Chicago and Philadelphia—to build Municipal Hospitals. These institutions were managed by local men, inexperienced and untrained, whose chief concern was economy rather than humanity. Lack of standards, abuses of various kinds and lack of uniformity are the outstanding features in county and municipal care of the insane and without doubt hastened the movement for state care.

The first pauper insane state hospital was established at Worcester, Mass., and opened in 1832. The next was in New York, 1843. In Massachusetts, three classes were eligible to admission: First, those persons who had been committed by Justices of the Supreme Judicial Court or Justices of the Peace, to jails; second,

town pauper-lunatics who were confined in poorhouses and those persons who had been contracted out to jail keepers and House of Correction officials. The third class included all those insane not mentioned in the other two classes.

The development of the state hospital was slow and materialized after severe struggle. When humanitarian sentiment became fully aroused, its expression was noted in the erection of well organized buildings, pleasant situations and modern methods of heating and ventilation, but no pains were taken to study the personal comfort of patients. Airing courts, surrounded by high walls, did not add to the welfare of patients. A sort of *laissez-faire* policy existed in the hospital; patients who destroyed their clothing went without; those who destroyed bedding or refused to lie in bed, slept on the floor, etc. Until 1880 mechanical restraint methods were extensively used and were believed to be absolutely essential in caring for the insane. The theory of treatment was to "overcome patients through fear, to break their wills" and to teach them that stronger wills than theirs were in authority. Gradually non-restraint methods were introduced, first in Canada, then in Michigan—soon followed by New York, Massachusetts, and other states. For a long time these non-restraint methods were sporadic and not entirely successful as no outlets for the energies of patients had been provided; with the introduction of industries, recreation, amusements, etc., these methods became successful and within the last 25 years have made their way throughout the United States. In Massachusetts, the state policy of mechanical restraint (with rare exceptions) is forbidden by law.

It is fair to presume that the present methods of caring for the insane would have been long delayed but for the marvellous work of Dorothea Dix, whose strenuous battles for the welfare of the insane resulted in reforms commencing in Massachusetts and spreading throughout the country and in some parts of Europe and England. In Massachusetts her efforts led directly to the enlargement of the Worcester State Hospital.

State care, which developed naturally, is the care by the state of the dependent insane as state charges and is in no way under the supervision or management of county or town officials. The advantages gained are the welfare and well-being of patients and are the first consideration. As far back as 1811, Doctor Wyman, first superintendent of the McLean Hospital, advocated

the "judicious moral treatment of insane patients" in which he recommended employment, such as sewing, garden work and recreation as valuable for the minds and bodies of patients. He believed in and advanced the idea that "the law of kindness was the all-pervading power of moral discipline." But he was a man far in advance of his time and his theories met with considerable opposition. Those who visited state hospitals a generation or two ago found large numbers of patients whose condition was deplorable; they were noisy, destructive, untidy, incapable of employment because of more or less constant restraint and seclusion.

The state hospital of today, which is a far reach from the county jail and asylum of yesterday, is both custodial and educational. The policy of early days was economy in caring for dependents: the policy of today is based on humanitarian principles; then it was safety for the public, now it is the restoration of the patient.

In reading the history relative to the care of the insane, one is impressed with the fact that conduct disorder has ever been the cause of confinement. The early methods of treating such disorders, beating, binding and otherwise cruelly treating them, stand out in marked contrast to modern methods of caring for mental patients. Recognizing the fact that such patients are frequently free from bodily disease, so far as can be determined, and that conduct disorder is the outstanding feature, the keynote of treatment is education; hence the various forms of industry, exercise, recreation and amusement which characterize the modern state hospital. Patients are now treated with a view to assisting them to adjust themselves to the existing social order. They are regarded as patients, not paupers. In place of economy, social welfare is the basis of treatment. The state policy of today in the care of the insane may be briefly defined as one in which all those factors which have a bearing upon mental health are carefully and scientifically considered. Reformed laws removing the insane from the care and custody of justices of the peace, overseers of the poor and jailers make it possible to give such persons medical care. The conditions surrounding them in state hospitals are arranged for the purpose of promoting physical and mental health. The development of occupational therapy, mechanical arts, recreative amusement, etc., has had a quieting and helpful effect upon patients; the policy of boarding special patients in private homes under good normal conditions; the establishment of psychopathic wards in general hospitals and psychopathic hospitals for

the study of borderline and incipient cases and investigation of mental diseases, and the recent establishment of social service—are all indications of an enlightened policy in state care of the insane. Such care insures efficiency, standardization and uniformity and makes for progress.

All the contributing factors, medical and social, which have played a part in the breaking down of the mental faculties should be intelligently considered. It is interesting to note that the causes of mental illness as given by the laity are largely social causes:—poverty, hardship, worry, overwork, alcoholism, immorality, irregular habits, unfortunate love affairs, social maladjustments, etc. It is obvious that these factors cannot be lightly ignored for they must perforce play a part in future treatment. Doubtless the importance of social factors has long been known to the hospital physician, but heretofore there seems to have been no practical way of dealing with them until social service, having proven its worth in the general hospital, was gradually introduced into the state hospital. The purpose of this department is for the social welfare of patient and community and for effective hospital treatment. This department of state hospital organization is young and a great deal of elementary work has been obviously necessary. The functions of social service in the state hospital will be guided largely by the interpretation which hospital superintendents and governing bodies give of the work. At the present time the main functions of social service are to contribute to psychiatric knowledge and to aid in matters of social adjustment.

The value of social work to any state hospital depends largely upon the quality of the case-work. Social problems under which the patient broke down, employment, habits, moral and physical environment, are all significant from medical and social standpoints. The knowledge of these factors plus the medical findings will generally indicate a form of treatment and aid in matters of social adjustment. Teamwork is absolutely essential between physician and social worker if good results are to be obtained. The psychiatric social worker, at the present time, largely confines herself to the study of environmental conditions and their relation to mental states. When this work is more firmly established, doubtless the study of personality will be equally important and effective, especially when one considers that problems of personality constantly occur in matters of adjustment to home life, community conditions and industry.

Social history work is an important branch of this department and means that the best outside resources are used in obtaining knowledge which the physician may require in matters of diagnosis. Such work aids not only the physician but assists the hospital in acting intelligently and constructively when placing patients again in the community.

Next in importance to social case-work and history-taking is community work. To a large extent, social organizations in the community supply the machinery for the readjustment of patients. The problem of the psychiatric worker is largely to coördinate their special services for hospital use. The contact with these agencies must be made in a close, intimate manner in order to secure efficient results. The hospital must be in close touch with the schools, charitable agencies, recreation centers, employment agencies, hospitals and churches, through its social service department. Another branch of work which it is the privilege of the social worker to perform is to contribute knowledge regarding the social laws of mental health wherever the need for such may appear. An interesting part of the earlier duties of the state hospital social worker has been to impart correct information regarding hospital methods. Ignorance in regard to state care of the insane is by no means confined to individual cases. Fear of state institutions is being substituted, in a most encouraging degree, by coöperation wherever hospital methods are clearly understood by relatives and other interested persons. All possible encouragement is given to those in need of medical advice to use hospital resources. The interpretation of the hospital to the community and aid to individuals and social groups means that coöperation is being established and that hospital and community are joining forces for a common purpose.

Recent studies have shown the possibilities of preventing many forms of mental illness—so-called borderline cases between the normal and defective groups—especially those types of disease connected with fatigue, anxiety and social maladjustment. In many instances suitable and early knowledge would result in prevention of more serious conditions. The establishment of psychopathic hospitals may serve to open the way for much preventive work. The psychopathic hospital, established mainly for the study and investigation of mental diseases and for the care of early cases of mental illness, should have a well organized social service department in order that the social studies and investiga-

tions may contribute to medical knowledge. The out-patient clinic, which is the natural outgrowth of the modern state hospital, serves the double purpose of keeping in touch with former patients and acting as an educational center for needy individuals outside the hospital who desire information. The future development of these clinics, at which the social worker is usually present, will doubtless mean that they will be as commonly used as those of a general hospital.

Social service, from the viewpoints of education and legislation, covers a broad field. The community should know more of mental disorders, causes and prevention, and should be encouraged and urged to assume much the same attitude which it now holds toward tuberculosis and syphilis. The proper education of children, especially as regards early mental development and social habits, is vitally important. School, or even college education as such, does not necessarily fit one to meet the difficulties of everyday life. The combination of physicians, clergymen, teachers and social workers along lines of mental hygiene will help tremendously to form public opinion in the field of mental health. Statistics, compiled by such persons, must eventually lead to special legislation in the department of mental health.

The movement to make social service an adjunct to psychiatric treatment is apparently gaining in popular favor and will doubtless become a recognized part of the state hospital organization scheme. In Massachusetts, the Commission on Mental Diseases has recently adopted social service as part of its policy in caring for mental patients and holds a place on the state program. This work is being gradually introduced into the various hospitals connected with the Commission; out of 14 hospitals, 10 are now engaged in some form of social service. A most encouraging feature of a recent survey of these institutions was the practically unanimous desire expressed by superintendents for such work. This section of the states's program indicates that social service, both intra- and extra-mural, connected with the institutions under the Commission, is to be established on a firm basis. A comprehensive plan for coördinating and developing the various phases of the work includes uniform records and statistics, standardization of methods and correlation with the various community resources. Subdivisions of the work are:—development of case-work, social investigation, history work, placing and care of boarding patients, after care work, special studies, etc. A

division of the work yet to be developed is that connected with the out-patient clinics. The demand for workers is greater than the supply and necessitates the establishment of a system for training students and volunteers. A tentative plan is in process of formation.

The future development of psychiatric social service in connection with state hospitals will depend largely upon the organization of the work and upon the qualifications, natural and acquired, of persons who enter the service. The social service department of a state hospital, although distinct in itself, should be so organized and developed that it will fit smoothly and harmoniously into other departments of institutional work and enable its machinery to run effectively. In every respect its purpose is to fit into the general policy which the state has adopted in caring for its mentally sick and defective. The spirit of social service should pervade the hospital atmosphere and serve as a constant reminder to those interested in patients and in the general care of the mentally disordered that social welfare is more valuable than economic and scientific methods—that human kindness is a more powerful agency than the exercise of temporary authority or the exhibition of power and in reality *is* "the all-pervading power of moral discipline."

THE FUNCTION OF THE PSYCHIATRIC SOCIAL WORKER IN RELATION TO THE COMMUNITY*

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THE activities of a social worker in a hospital for mental disease parallel the same work in a general hospital, though there is emphatic need of special training to deal with the mental problems involved. It is the social worker's privilege to assist in discovering the contributing causes of the patient's breakdown, and to render whatever service will promote his welfare while in the hospital and help to reëstablish him in normal life when he is allowed to leave. The function in the community of a social worker for the mentally disabled is less well understood; it is not so apparent where and how she will get into touch with those who need her services. Her protégés may not come to her listed and diagnosed as in a hospital, with an outline of future treatment sent by the physician. They may never have been in a hospital at all. In many cases, they will not *come* at all. She must go to them. It is evident that, besides the general means established to secure mentally wholesome education and environment for the community, there must be an intermediary who can deal with those who are beginning to evince mental abnormality. Some years ago Dr. August Hoch, in an article on *The Social Side of Psychiatry*, said, "If we wish to adopt measures for prevention upon thoroughly practical grounds, we must recognize that our field lies in measures which are primarily aimed at individual cases—measures which aim at getting at the cases much earlier than we do now." And again, "I am sure we could help such early cases if we could really treat them when such difficulties are seen to arise. Many could be saved if we could take them out of their environment, enter into their struggles, place them in an atmosphere where stimulation of healthy interests would be the uppermost aim."

Dr. E. Stanley Abbot says, "Probably from 16–20 per cent of the yearly admissions to hospitals for the insane are due to breakdowns in persons who were unable to withstand hard, continuous work, or the exhaustion of illness or pain, or the sudden and

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intense, or the long continued, stress of conflicts between opposing desires, ambitions, and duties, or the strain of prolonged responsibility." And again he says, "Perhaps a half, possibly more, of the manic-depressive psychoses might be prevented."

Dr. Ferris, formerly President of the New York Commission in Lunacy, says, "The fourth important cause of insanity consists of fatigue, stress, and strain in specially susceptible individuals. Stress and strain are very often due to improper environment, including housing, clothing, occupation, recreation, food, and habits of thought." Surely here is indicated a sufficient and legitimate field of work for the psychiatric worker. To promote this preventive work, which is the most valuable in terms of conservation, she must be prepared not only to help those who feel their need, but also to search out the incipient case, the border-line neurotic, and the troublesome unrecognized high-grade defective, whose maladjustment to society is not understood. With the advice of a psychiatrist, she can proceed to readjust the personal, social, or industrial factors in each separate problem. A grounding in psychology, added to some training in psychiatry, and an acquaintance with the more frequent forms of nervous and mental disease do not turn a social worker into a psychiatrist or qualify her to deal single-handed with the mentally disabled; but this training makes her more keen to detect early symptoms and more anxious to secure the advice of a mental specialist. Under his guidance she can intelligently undertake the suggested restorative or protective treatment. The psychiatrist will welcome her assistance as cordially as will the family of the patient.

The presence in a city of a worker who knows something of mental diseases, and is known to stand ready to help with "worries," is often enough to bring to her problems that would never be referred to a charity organization or to public health advisers. Sufferers themselves may seek her advice, or their anxious families may come for help.

An intelligent girl of twenty-two, working as a telephone operator, found herself growing constantly more depressed and more painfully self-conscious. It was very difficult for her to adjust herself to ordinary conditions of work. She felt that she was different from other girls. Anxiety pressed upon her, and she began to fear that she would be unable to continue the work which helped support her mother and sisters in a distant city. A chance pamphlet brought her to the psychiatric worker for advice.

Her family history was highly suggestive of probable breakdown. The father, a worthless man who had been guilty of crooked dealing in financial matters, had left the family to support themselves. He was said to have been always very nervous and irritable. The mother was overanxious, depressed, and weak-willed. The five sisters and one brother showed various forms of mental lack of balance, such as passionate outbursts, exaggerated shyness, seclusiveness, irregularity at work. In a word, it was a family providing fruitful soil for the mental catastrophes of adolescence. This oldest girl was examined and advised at a mental clinic, and was then placed in the social worker's charge to carry out a program that regulated her recreation, her diet, her books, and her companions, and directed her thinking. In three months she had gained five pounds and had acquired a self-control that secured her normal enjoyment of wholesome pleasures. Her intelligent appreciation of what had been done for her induced her later to bring to the clinic other members of the family for advice. For one sister the best that could be done was to delay the development of dementia praecox for a few months, but a younger child was cured of passionate outbursts, and a young brother tided over a period of exaggerated sex consciousness.

Frequently the general practitioner realizes that a case of incipient mental disease demands constant, intimate advice and a supervision that he has neither the time nor the opportunity to give. Such was the case when a family physician referred to a psychiatric worker a young Jewish girl who, he feared, was definitely insane. Examination at a mental clinic resulted in a diagnosis of a border-line condition in urgent need of general supervision by a trained woman. The girl was sixteen and had been working since fourteen in a factory where she could not avoid hearing obscene stories related by some rough co-workers. These stories had made a lasting impression; they were intensely repugnant to her. The struggle to suppress these repulsive ideas had brought her to a state of collapse. She could not sleep, wept copiously and almost constantly, would not eat, had lost twenty pounds in weight, and wanted to die to end the conflict. The family were sympathetic, but helpless. A short vacation, a change of work, and above all several frank talks which placed certain facts on a healthy, normal basis, coupled with a general supervision of diet, recreation, and companionship, were sufficient to work a remarkable change. In a few months she was rosy,

smiling, happy at work, and had regained her lost weight. The family regarded her changed condition as a miracle. There has been no recurrence of the trouble in three years.

Sometimes the one effective treatment will be urged by no one but a psychiatric worker. In a city well supplied with the usual philanthropic and advisory agencies, a woman came in deep anxiety to ask advice about her husband's condition. She was in constant dread of finding him a suicide. For a year he had brooded on self-destruction; his restlessness drove him into long walks until he was too exhausted to set out again; his indecision was a torment, his depression abysmal. Three general practitioners, in the course of a year's treatment, had given him sedatives and advised open-air exercise. This man had broken down four years previously, and by prolonged treatment at a mental hospital had been sufficiently restored to enable him to resume his work as engineer on a fast express train. In an interview with the man himself he acknowledged, after agonized protest, that he knew he would be better in a hospital where some one other than he himself would regulate his conduct. One day more of the exhausting conflict and he came to say that if the worker would herself take him to a state hospital, he would go at once. This was done, and after some months of treatment he was again restored and back on his engine. This was a frank case of manic-depressive insanity in which the patient should have been spared months of suffering and constant danger of suicide.

While the comfort and help given to actual sufferers is a sufficient reason for any effort that may be made by a community worker, the protection of other unaffected persons may give a double value to her work. Workers untrained in psychiatry, and philanthropic societies unused to dealing with the mentally diseased, are very likely to shirk responsibility in this difficult kind of problem. In this way dangerous conditions are often allowed to persist. An infant-welfare nurse reported that the mother of a three-weeks-old baby had been behaving and talking curiously for some months, and that the doctor said she was intemperate and perhaps insane. He had taken no steps in the matter whatever, though he had said he was sure the infant would die of mishandling or neglect, and the woman's condition was common knowledge in the neighborhood. The psychiatric worker secured an immediate mental examination of the woman which revealed an alcoholic psychosis with ideas of persecution and a tendency to impulsive

acts, rendering her a most unsafe guardian for the child. The woman's sister was brought from another city, the legal preliminaries were hastened, and within a day the mother was in the state hospital and the baby suitably cared for elsewhere.

A similar case was that of a Jewish woman, haggard and worn, who came to say she could no longer endure the terror she had suffered for two years from the frequent threats of violence made by her husband, who was growing increasingly irritable. He had given up work, and on her had devolved the task of supporting six children and protecting them from his violence. His examination at a mental clinic showed well-advanced general paresis and need for immediate action. Within two days the man was committed and the family relieved from an intolerable strain.

A well-known physician telephoned asking a psychiatric worker to give necessary advice and help to the family of a woman he had seen and treated only a week before. The woman, sixty years old, had been worried for a year by fears of misfortune, and had finally almost succeeded in an attempt at suicide. After a few days of semistupor, she had raved of persecution and had had hallucinations of sight and hearing. The doctor had sent her to the country to a sister with no warning of her dangerous condition, and it was not surprising that very soon she crept up behind the sister and struck her on the head with an axe. The blow was fortunately not fatal, and the sister tried for some days, until exhausted, to guard the insane woman. Then it was that the psychiatric worker was notified. She was soon able to persuade the family that immediate commitment was the only course, and to help with the necessary procedure. Within a day further danger was averted by having the woman placed in the state hospital.

The protection needed by the community is sometimes moral rather than physical. Since feeblemindedness actually means an adult body governed by only a childish intelligence, there will always be a moral problem while these defectives are at large.

A feebleminded girl of fourteen, with a mental age of four, already a pupil in a class for defectives, was developing into a moral plague spot, contaminating the other pupils and the children in the public playground. Her father was alcoholic and her mother densely ignorant and suspicious of any institutions. No one seemed to be able or willing to deal firmly with the problem. It required many visits to the family, to their priest, to the city

authorities, to the city courts, and to the school board, before the psychiatric worker succeeded in placing the child in an institution for the feebleminded.

Instances of pronounced disease which require institutional care both for their own and for the community's sake are often cases that might have been prevented had the earliest symptoms been recognized. The most valuable psychiatric work that can be done in a community is obviously that which prevents the development of serious conditions. The present problem of reëstablishing in civil life the discharged soldier is proving to have in it a large psychiatric element. More than one-half of the soldiers who applied in one month for assistance at the Red Cross Home Service Bureau in a large city showed marked evidence of a maladjustment which had existed in both their military and their pre-war life. Of these a considerable number showed definite symptoms of mental instability. To deal with them effectively requires an examination by a skilful psychiatrist who should diagnose the condition and direct the worker in her task of supervision and reconstruction. These soldiers must be saved from unsuitable work or more destructive idleness and gradually reëducated to assume their responsibilities. This war-time problem is not a new one. It is simply a thrusting into the limelight of conditions dimly perceived before. There exist always in the community a number of people who manage with difficulty to bear up under adverse conditions of life. Faulty environment or ill-suited work provides a wearing process that brings catastrophe. Timely advice and assistance from psychiatrist and social worker will often remove difficulties and give relief.

In a country that draws so many of its inhabitants from the Old World there occur many cases of lonely people for whom no one feels responsible when mental disease is seen to be developing. Employers and landladies wash their hands of responsibility when work and money are not forthcoming, and the confused irrational man or woman does not turn to ordinary channels for help. It takes a comprehending social worker to appreciate the needs and dangers of this condition and to initiate efforts to get it under control. If such a specially trained worker is known to be available in the community, some one finally brings the problem to her.

The owner of a rooming house reported that an Englishwoman in one of her rooms had been heard talking to herself all night, seemed confused and exhausted, and apparently was nearly

starving. Efforts for a few weeks to restore her through food, friends, and work were not successful because of her peculiarities, which steadily increased. A psychiatrist diagnosed the condition as dementia praecox. The patient showed marked delusions and had hallucinations of hearing which centered about a casual acquaintance, a decent mechanic. Very soon she was trying to put detectives on his track and struggling desperately against the influence of his supposed voice.

She was very reticent, but finally her story came to light. She belonged to a prominent English family, now reduced in wealth, and had been a governess in her youth. Unfounded ideas of the significance of ordinary courtesies shown her by a curate, together with annoyance at her family's efforts to make her see reason, soon increased her early eccentricities of behavior. She left home against advice and came to this country without money or friends or prospect of work, and for five years had kept up a losing struggle for existence, always hampered by her suspicions. Her conduct finally became so troublesome that, on the doctor's advice, she was placed in a private hospital by the psychiatric worker until her family could be notified. They were filled with gratitude for her care, and permanent arrangements were soon made. Her sister has twice come to this country to assure herself of the care given, and will take her to England now that the war is over.

A young Polish girl who was without relatives in this country, but who had worked as a servant here for five years, became deranged, full of fears, and twice tried to kill herself. For some weeks, while doctors were unable to agree about her condition, a psychiatric worker kept her under supervision and arranged for temporary work. Later, when the symptoms became unmistakable, the worker secured her admission to a state hospital, and had a guardian appointed to protect her savings.

All these types of cases make up the great group of those who need preventive measures or early treatment to control their condition. There is also another group who need advice and supervision that can be given only by some one who understands their needs. These are the patients discharged from hospitals for mental disease, able to come back to family life and to begin slowly to pick up the thread of normal living. The patient's family must be taught how to receive him—neither as an object of suspicion nor as differing from themselves. Some guidance

must be given in dealing with such minor peculiarities of conduct as may yet linger. A right atmosphere in the home will do much to make recovery permanent. Readjustment is gradual, and difficulties arise that do not trouble the mentally stable. Ignorant prejudices of the public must be overcome, and the patient's confidence in himself restored. Suitable occupation must be found; mental backsliding must be prevented. This service for former patients is known as "after-care," and is daily proving its value in work done for many state hospitals. It must be given by some one who is alive to the special needs of such convalescents and who knows how to utilize for them the resources of the community. Where state hospitals have their own social workers, this phase of the work more properly belongs to them, but very few state hospitals are so provided as yet.

How shall one find the incipient cases? Comparatively seldom do they ask for assistance themselves. It is through social and industrial channels that the worker must seek them out. A brief explanation of the possible causes of abnormal conduct and of the early symptoms of mental breakdown will enlist assistance in locating them. Church visitors, school-teachers, settlement workers, factory overseers and foremen, club leaders, district nurses, police matrons and inspectors, city-court judges, probation officers, truant officers, charitable organizations, playground supervisors, clergymen, all will find occasional need of the psychiatric social worker's services in some unusual situation; medical men will gladly turn to her for the supervision they have not time to give a neurotic patient, and because of her mental hospitals will be able to return more quickly to family life the patient who still needs supervision.

While this worker for the mentally disabled stands ready at all times to give her mind and heart to the service of those who are ill, she may make a yet bigger contribution to community welfare. Prevention of mental disease can best be achieved by spreading knowledge of the preventable causes. Many opportunities can be secured by the worker to tell local clubs or societies of the disastrous results of alcoholism, syphilis, and drug habits in producing insanity, and of the influence of heredity in increasing the number of the feebleminded. The mental health of the community will be promoted in proportion as these dangers are known and avoided. The researches of the world's foremost psychiatrists have taught us the danger signals and the pitfalls in mental

development, and a psychiatric worker will feel her responsibility to disseminate this knowledge.

To do effective work in a community, a psychiatric social worker must have opportunities for securing the advice of a psychiatrist. Only with his diagnosis and advice can she safely plan her course of action. Very many of her patients will not be able to pay for the services of a specialist. Very many could not be persuaded that their condition justified such an outlay. A free mental clinic is therefore an essential if the worker is to have the scientific basis she requires in dealing with these difficult individuals. On the other hand, a mental clinic cannot be very valuable without a social worker. Without a clear picture of the personal, social, and economic surroundings of a patient, it is often difficult for the psychiatrist to make a diagnosis or to outline a course of treatment. It is also of little use to diagnose and prescribe unless there is a prospect of the directions being carried out intelligently.

What, then, should we say are the functions of a community worker for mental cases?

To search out individuals who show evidence of serious nervous and mental strain and to induce them to secure competent advice;

To regulate the activities and surroundings of those incipient cases whose threatened breakdown may be prevented by prompt compliance with the psychiatrist's instructions;

To break down the existing prejudice against hospital treatment for those whose condition demands it;

To assist those who must obtain hospital care by carrying through the often involved legal proceedings necessary to obtain it;

To act as the friend of the mentally ill who may be friendless, giving them the protective care ordinarily given by the family;

To supervise and reëstablish in normal life patients discharged from mental hospitals;

To act as a medium for the education of the public in the prevention of mental disease and defect and in the general rules of mental hygiene.

If we are to deal more effectively with this great problem of mental disease and defect, we must multiply those agencies which offer prompt aid in conditions of mental abnormality and which promote prevention. We must see established many more centers for advice to the neurotic and the psychopathic. We must place within their reach the necessary help of the psychiatrist and of his assistant, the psychiatric social worker.

PLACE AND SCOPE OF PSYCHIATRIC SOCIAL WORK IN MENTAL HYGIENE*

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THE history of the evolution of civilization demonstrates that progress is due fundamentally to the development of the intellect in mankind. As man has advanced intellectually, he has acquired, increasingly, capacities for perceiving problems of deep significance to himself and to the general welfare, and has striven to find means for solving them. The advancement of society depends upon the intellectual level of the people. Progress takes place in proportion to man's capacity for conscious appreciation of his needs and in accordance with his ability to discover resources capable of meeting them.

Leaders of all ages have been persons of superior mental caliber. Our greatest leaders have been those individuals who not only have contributed to society intellectually, in the narrow sense of the term, but who have expressed in their lives great moral and spiritual strength. We recognize these and allied characteristics as qualities of mind—as expressions of a superior intelligence—and realize that it is through the expansion of these attributes of mind that man advances and the evolution of the race takes place.

In the course of cultural advancement there have been sporadic efforts on the part of men and women to search into the mysteries of psychic phenomena and to explain mental life. Scientific study of the mind from the angles of psychology, sociology, and even the physical sciences, made little progress until the nineteenth century. It is only within recent years that our knowledge of the mind, either in health or disease, has been sufficient or comprehensive enough to enable us, in the group sense, to recognize that our problems, discussed from any angle we may choose, are traceable in a great measure directly to the state of mentality of the individual or the group, that our *greatest* need is a more extensive knowledge of our mental capacities and limitations and a greater understanding of how best to conserve our mental powers, since upon our mental health depends our national strength and future progress.

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Conservation of mental health—in other words, mental hygiene —is not a new idea to any of us, but it has been a subject that has not been given sufficient emphasis in the past. To-day more than ever before it is of concern to a larger group of people whose interests primarily are along other lines of endeavor; it is becoming of more universal interest than one at first realizes. This has undoubtedly been due to two causes: first, the attention attracted to the subject through the mental hygiene educational propaganda, the wider circulation of publications of scientific studies especially relating to social psychiatry and allied subjects; and, second, the national need for assistance in solving present-day problems, both those of the community and those of the individual.

The increasing complexities of modern life demand an ever-increasing "speeding up" of the mental faculties in order to meet the requirements of the times. The result of this high-pressure activity upon the people is demonstrating itself in many ways, of which incomplete adaptation to environment is the most conspicuous. We may lay much of the present-day restlessness, discontent, uncontrolled manifestation of emotion, faulty judgment, and blind reasoning to war conditions, and a great deal can be said in favor of this view; but an analysis of conditions before war times shows the same upward curve in these characteristics. The public registered itself then as it is doing now in its behavior. Statistics, as well as our personal observations, indicate an increasing number of so-called "nervous and mental breakdowns." We note also the tendency of many supposedly intelligent persons to disregard their mental health completely. This tendency is shown in the lives of many of our prominent men and women, by their unwise expenditure of effort, their exaggerated state of emotional tension, and their haphazard mode of living—the little time reserved for reflection, repose, or adequate rest and the almost abnormal craving for emotional excitement. The people of to-day—I speak of pre-war times as well as of the present—are seldom in their homes, and when they are, little time is spent in preparing for "to-morrow." One may ask, "Why lay these problems all at the door of the mind?" and the answer comes, "Because it is the mind that either controls or does not control the activities of man."

The world war quickened the intelligence of most of us. It presented problems that of necessity created capacities for solving them. Our social consciousness expanded more fully during this

short period of time than could have been otherwise possible. Man became less conscious of his own welfare and more aware of his obligation to his neighbor or his country. With this advancement came the need for conservation. In his eagerness to be of service, man neglected himself. His rushing forward, so to speak, had its disadvantages as well as its advantages, for the stimulus and the resulting activity sometimes proved too great; we need only to look around us to observe its effects. This emotional instability denotes a crying need for mental hygiene.

That in mental hygiene we have discovered the panacea for all our mental ills and that the application of the principles already evolved will prevent future functional disorders or mental disease, or even allay present-day conditions, is, of course, not true. We have still a long road to travel. But a brief survey of recent activities shows that mental hygiene has taken great strides and that it stands as one of the foremost educational movements of the day.

We know that the national and state committees have culled from scientific literature material of value to the mental welfare of the people; that this literature, which is rich with information concerning the factors that contribute to nervous and mental invalidism, has been given a wide circulation; and that it has paved the way for a more comprehensive understanding of our community problems, thereby opening new avenues of thought through which we may arrive at more adequate methods for protecting our mental health.

The achievements of this educational campaign are manifold. The results are felt not only by educators, but by the general public. They clearly indicate the public's trend of thought and show that the people are analyzing intelligently their community problems and are finding the ways and means for meeting them. Already, in many states, bills have been passed providing for more adequate care and treatment of the mentally handicapped; in addition, efforts are being made to secure legislation that will place upon the state the responsibility for the indeterminate care and supervision of those individuals whose lives and histories demonstrate their inability to adjust themselves to community life. Emphasis has also been placed upon the necessity for provision by the state of adequate facilities for the early examination of individuals who show only slight neuropathic or psychopathic tendencies, and for the institution of mental clinics.

It is quite probable that we are on the threshold of still greater achievement, for the workers in the fields of medicine, psychology, and sociology are contributing data of immeasurable value to students of mental hygiene.

The literature of these allied professions shows their realization of the interrelation and interdependence of their respective fields. It shows that the problems we hope to solve have their roots deeply imbedded in the soil of all three sciences, and that the adjustment of conditions depends largely upon the combined efforts of them all. These conclusions are suggestive only, but they indicate that we have already gained a broader conception of our work which will eventually result in a deeper understanding of mental life and a more skillful handling of our subject.

Mental hygiene has paved the way for the prevention of many of our organic nerve and mental diseases, but we are still far behind in our understanding and control of the functional disorders of the nervous system—the psychoneuroses, those nervous states that are characterized principally by manifestations of emotional disturbances, recognized as one of the most intangible of disorders and most prevalent in modern times. We have abundant data on the symptoms of these conditions, have developed our diagnostic nomenclature, have isolated many causal factors, and have made progress in our knowledge of the nature of their constituent parts. As an outcome of these discoveries, the emotional life has become the center of attention, and greater importance has been placed upon the value of research in relation to the psychology of the emotions. It is social psychiatry that has been responsible to a great extent for the unfoldment of these truths. Should we not look to it for continued leadership in the future?

Social psychiatry we may define as that branch of medicine which deals primarily with the psycho-social aspects of mental and nervous disease, thereby extending the field of psychiatry into those of sociology and psychology, in so far as these sciences contribute to a clearer understanding of the various phases of mental abnormalities and affect their treatment.

Psychiatric social work came into being at first as a subdivision of medical-social work, but is now recognized as a separate division of social work. Psychiatric social work may be descriptively characterized as a laboratory in which the field workers of mental hygiene, through the medium of the so-called "social case-work method," study and treat the social-psychological malad-

justments which have a definite relationship to mental disease. The work is primarily that of individual service for those who suffer from the various forms of nervous and mental disorders. The material is obtained from personal contact with these sufferers, from their families, physicians, and employers, from school and public authorities, and from public and hospital records.

The students in this workshop are individuals whose natural gifts, combined with education, training, and experience, equip them to discern intelligently, quickly, and accurately, in the vast mass of psycho-social material at hand, those facts which are of value to psychiatry. These students are thus qualified to act as consultants and assistants to neuropsychiatrists not only in bringing to them data of diagnostic interest, but in aiding them in their treatment of disorders which indicate a need for a readjustment of social conditions or for personal reëducation.

In presenting psychiatric social work as a laboratory for field workers in mental hygiene, we give it a strategic position that to a certain extent establishes its relation to mental hygiene.

The value of this work cannot be estimated wholly in terms of fact, owing to its being still in the experimental stage of development, but we conclude from observation and from reports of its activities that its field of operation is rapidly expanding, that it is contributing to our knowledge of the social causes of nervous and mental disease, and that the field workers, through their personal contacts, are reaching those individuals in the community who, because of their lack of advantages or mental equipment, would not otherwise have access to such help as mental hygiene can offer them.

In order to obtain a clear conception of the scope of activities in this field, it will be helpful to survey briefly some of its accomplishments.

In the study and treatment of dispensary patients who suffer from the so-called functional disorders of the nervous system known as neurasthenia, psychasthenia, and hysteria, psychiatric social work has made a definite contribution.

Until recently these patients did not receive sufficient attention in the out-patient departments of our hospitals, owing to the fact that their disorders were looked upon more or less lightly by physicians. In addition, the pressure of clinical duties, the many cases demanding attention, made it necessary, in general, for the clinic physicians to confine their efforts to organic disturbances of

the nervous system. With greater knowledge of the causes of functional disorders grew the conviction that these conditions were of the utmost significance to their victims and to society at large; that it was important to study and treat them from the social and psychological, as well as from the medical, standpoint. As a result of this broader conception of therapy, social workers have been placed in a number of neurological and mental clinics to establish an adequate coöperation between medicine, as represented by the physician, and environmental conditions, as represented by the social worker.

In supplementing the physician's work in the study of the psycho-social maladjustments that have a bearing upon the invalidism of these patients, and aiding in the readjustment of these when possible, the social worker uses the social case-work method in investigating the patient's environmental conditions, hereditary influences, and temperamental tendencies. The method is used to secure data to assist the physicians in rounding out their clinical examinations and thus make it possible for them to give more adequate advice as to treatment and procedure in the reëducation and reëstablishment of the patient.

It is impossible at this time to estimate the importance to the mental hygiene movement of the reëducational work of the psychiatric social worker, but a study of the social records of sufferers from these nervous disorders shows progress along curative lines and reveals certain points of interest.

The patients who receive the most benefit are those whose mental condition is good, but whose physical and mental environment has been extremely poor. These patients are eager for help and respond readily to treatment. Many have been groping blindly for health and simply need to be given a few fundamental facts about their mental attitude in order to evolve for themselves a workable philosophy of life. Others have serious character defects which are difficult to adjust, but with the encouraging guidance of the physician and the social worker, they gain self-reliance and a healthy mental attitude.

Patients whose mental equipment is not very good and whose environmental circumstances are poor do not respond so well, but it has been found that, through careful supervision and with assistance in the readjustment of their home conditions, progress has been made, though only in a palliative sense. There is a large group of patients who, because of constitutional weakness,

have not the stamina to gain any help through this method of treatment, but it has been possible to help them through the coöperation of relatives and others. In a case of this kind the psychiatric social worker instructs the relatives in the principles of mental hygiene, gives them a better understanding of the patient's condition, and stimulates their interest in helping him.

It seems reasonable to conclude that prevention of these disorders depends to a large extent upon adequate early training, for when they are finally analyzed, it appears that they are the expression of faulty character development and habit formation.

In the care and treatment of the insane and the feebleminded, psychiatric social work has made for itself an important place. It is hardly necessary to mention that adequate treatment of these patients depends upon their receiving suitable community supervision, and that it is of primary importance to detect cases early in their development.

Psychiatric social work is making this early treatment possible. The social workers are supervising the patients who are not suffering from severe mental disorders and who are living in the community. They are acting as counselors to their families, teaching them how to care for these patients intelligently, and showing them the need for suitable employment and for conservation of mental and physical health.

Many of the state hospitals for mental disease, the schools for feebleminded, the courts and reformatories, have attached to their staffs psychiatric social workers who are aiding the physicians in diagnosing difficult border-line cases by securing past personal and family histories. The workers are also supervising patients who have been discharged or are on parole from these hospitals. This work needs no explanation. It is valuable as it means among other things more immediate segregation, when this is necessary, better supervision, and better care for the mentally disabled.

In the field of research psychiatric social work is making some headway as is shown by the social data being published by various workers as a result of their work.

An intensive study of the economic efficiency of one hundred epileptics who received treatment in the neurological clinic at the Massachusetts General Hospital in Boston has revealed a number of interesting facts that have been overlooked by the medical profession and by community-welfare promoters.

The study shows that a large percentage of epileptics of working age support themselves and even contribute to the support of their families. It is exceedingly important that the full significance of this fact should be appreciated, for in the opinion of many persons, laymen and physicians alike, the mental capacity of epileptic patients is rated as distinctly low; most institutional data hitherto at our disposal have seemed to emphasize this fact. The investigation shows, as well, that these patients are compelled to change their work frequently because of their handicap—the seizure or attack—that they are often obliged to accept work that is uncongenial and sometimes inferior to their capacities, and that the length of their service depends more upon the lack of attacks than upon their efficiency or the character of the occupation. The majority of patients who are not self-supporting—those doing unskilled labor principally—would be able to contribute far more toward their own support if they did not so often lose their work on account of their attacks.

Patients who have frequent or severe seizures generally lose their positions, no matter how great their suitability may be in other ways. Employers discharge them in most instances as soon as their handicap is discerned. Employers and fellow workmen are rarely, if ever, willing to take the responsibility of looking after their companions at these times, and are often seriously alarmed by the occurrence of the attacks.

These observations indicate that a large number of community patients have sufficient economic efficiency to earn a living if placed in suitable positions and relieved of the fear of losing their work. It appears that this continual anxiety concerning their positions is a greater factor in their mental deterioration than has been supposed, and that work is helpful as a therapeutic measure, if for no other reason. In consideration of these facts, it seems advisable to bring about some sort of coöperation between employers, the medical profession, and all who are interested in preventive measures, in order to plan for more adequate care of epileptics. Epileptics should certainly have the same opportunities as the physically handicapped, and there seems to be no reason why the less handicapped epileptics should not remain in general community industries. For those epileptics who have severe seizures, necessitating special conditions, opportunities, shops, might be provided in connection with the institutions that care for these patients.

The study also shows that epileptics of school age are frequently debarred from school on account of their attacks, although their scholarship has been reported as above the average. This suggests the need of providing in suitable ways for the adequate instruction of certain groups of epileptic children. Vocational education is suggested for those children who, because of their physical or mental equipment, cannot follow a school course, but who are not so ill that they need institutional care and are capable of being trained to support themselves, at least partially.

The part that psychiatric social work played in the army is indicated by the fact that it served primarily the neuropsychiatrists in the military hospitals as a medium through which they could obtain the past personal and family histories of soldiers suffering from war psychoses and neuroses. The advisability of placing specially trained social workers in military hospitals for soldiers suffering from these conditions was early recognized. It was more forcibly brought home when the men began to return from overseas, for many came with reports that contained very little medical information; not infrequently they came only with a diagnosis. As some of these cases presented symptoms which indicated that their condition had probably existed for years, if not from birth, and others came with a diagnosis of epilepsy, but had no seizures while in the hospital, these investigations frequently played an important part in the disposition of the cases.

The histories were secured through correspondence with relatives, family physicians, employers, schools, etc., and were used for diagnostic purposes and also to determine whether the soldier's condition occurred in line of duty.

It is interesting to note that histories were obtained in 90 per cent of the cases referred for these investigations at the military hospital for war neuroses at Plattsburg, New York, (U. S. Army General Hospital, No. 30). The majority of the replies were of value not only from a medical standpoint, giving the hospital authorities a clearer insight into the present condition of these soldiers, but from a sociological standpoint, showing the environments from which they came. A large percentage of the reports definitely placed the soldier's condition as not occurring in line of duty, but gave a clear past history of nervous and mental disorder.

Another phase of service was that of securing for these discharged soldiers adequate after-care through the Home Service sections of the American Red Cross. The nature of their disor-

ders required supervision of a special character, but owing to army regulations, it was impossible to give civilian organizations the medical information essential for the adequate handling of these cases. The after-care was, therefore, considerably crippled in its efficiency. The effectiveness of treatment of these disorders, in military as well as in civilian hospitals, depends upon the support and coöperation of the community after the soldier's or patient's discharge. Unless the organizations that have been given the responsibility for their after-care have a clear understanding of the medical as well as the social aspects of the cases consigned to their care, the results cannot be effective.

This, briefly, is a statement of the present place and scope of psychiatric social work in mental hygiene. It outlines a number of the activities and achievements of the work and in a measure indicates its value to the mental-hygiene movement.

Psychiatric social work is contributing to the advancement of social psychiatry in serving as an aid to diagnosis and as a guide in treatment.

The social records show data of social and psychological value in research in nervous and mental disease.

The future place and scope of this work in mental hygiene we do not know, but the reëducational work which is being done by psychiatric social workers is significant and indicates that this work will extend its scope of usefulness along curative and preventive lines.

CURRENT MISCONCEPTIONS REGARDING REFORMATION

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ASIDE from the minor mistaken ideas on the subject of reformation entertained by both offenders and some of their would-be friends and advisers, there are two major sophistries which defeat the good intentions of those holding them. No one may expect to reform who believes that (1) it is possible to do so without a long period of practicing reformation, and (2) that much help in reformation is available outside the offender's own thinking. In other words, the two commonly held, but damaging misconceptions regarding reformation are that a wrong method of living can easily be changed to a right one whenever the attempt is made, and that serving a short sentence in a reformatory will somehow "reform" one.

The favorite metaphor used by unthinking advisers of offenders is "turning over a new leaf." The idea is an unfortunate one and very ill chosen, for by it the impression is conveyed that a simple act of the will is sufficient to cover up the past and its effects on character and habits, and that one has only to try to do well in order to be reformed. The fact is that reformation is a long, hard, discouraging process which must be *practiced* intelligently—and successfully—for a long time before one may begin to have confidence in one's self-control and ability to resist temptation. Far from discouraging attempts to reform, however, knowledge of these facts should be a source of encouragement, a spur to setting about the undertaking in the right way. Knowing the task ahead to be long and hard, the sensible person will seek a good method, thereby, if he have adequate determination, many times multiplying his chances of success. If one attempts to lift an object thinking it weighs thirty pounds, when it really weighs three hundred pounds, one's first attempt will fail.

An analysis of the steps taken, consciously or unconsciously, by one who reforms is helpful and conducive to clarity. Many have reformed without analyzing the process; nevertheless, they have taken unconsciously the mental steps to be outlined. The first and essential mental activity, apparently, is a *feeling of regret* for the damage done oneself and others by ill-chosen acts.

The next logical step is the *intention to do better*. What should be the next step in the mind of one who regrets wrongdoing and intends to do better? It is *to make a plan* for better thinking and acting.

This third step needs some elaboration. All offenders, when at their best, take the first step above indicated; most of them take the second; but very few take the third. The first step is a mere feeling; the second involves some thinking and something akin to purposefulness; but in making a plan, the third step, constructive thinking is necessary. One may intend to build a house or a steamship, but unless one goes further than intending to do it, there is no tangible result. Now a plan of anything worthy, be it house or steamship or a proposed new law, may be made to look well on paper—i. e., in a drawing or in writing or in print. When we stop to think of it, every good and successful project has been reduced convincingly to written schemata before it was undertaken. Every aëroplane is carefully drafted before being built. Every bill presented to the legislature for consideration is carefully drafted beforehand. Yet many lives are lived without being planned, much less having the plan written out. To change a life over in the formative period (an almost impossible task after the close of that period—roughly estimating, after the age of twenty-five) is a far harder task than to live a good and successful life from the start. It is highly important, if one attempts to change one's life over, that one avail oneself of every help within reach. A written out—and of course carefully thought out—plan is a very great aid, probably the very best material and secular aid to reformation one may have, since it is about the only always sure means of success. If one has a definite plan, one knows how one may change one's life over in time, if one does not depart from the plan.

In making the plan, one should write down a well-formulated outline of living to cover a considerable time—three, four, five years—during which time one is to practice one's good intentions. It takes four years to secure a collegiate education—which makes something of a change for the better in one's life. Offenders have usually been several years on the downward course before they even start, in a prison, to think of reformation. If it takes five years to form the bad habits of thinking and acting that put one behind the bars, it will take at least as long to unlearn the evil and take on the good habits of life. Or, from another viewpoint, one year is not long enough to practice on one's plan for a

new and better kind of life; ten years is too long a period, probably; it would not be possible the first time to look ahead definitely so far. But in five years, lived according to a good plan, one could learn a trade, advance a neglected education, become one of a group of good associates and friends, accumulate a small bank account, and advance far on the road to reformation, all at the same time.

Obviously, however, this could not be done without a plan. By writing out a tentative plan in the beginning and adding to it and striking out from it and rewriting it again and again, scores of times, perhaps—in fact, each time that new and better ideas could be introduced—one would in the end have a plan to be proud of and one that would best fortify him, secularly, against yielding to the temptations he is sure to encounter.

Having made a working plan for a successful life, then, what is the next step to be taken toward reformation? Very few offenders of whom I have asked this question have given a correct answer. A superficial and often mooted answer is, "Go out and live the plan." To regard the above as the next stage would be to overlook a very important step, the fourth—i. e., to *decide* whether to adopt the plan and to *determine* to adhere to it and work it out as planned. Here is something more than thinking and far more than feeling: decision and applied will power—decision to deny oneself pleasure in order to begin progress and determination to stick to a good plan and let nothing turn one aside from it. The last step is obvious—*to live the plan*. This requires long-continued, well-chosen action and is the hardest of all the steps to take, just as the first was the easiest. A summary of the five steps in reformation may be expressed as follows:

1. A feeling of regret for unworthy living;
2. The intention to live more worthily;
3. The making of a plan by which to be guided;
4. The deciding and determining to adhere to the plan;
5. Living by the plan for the time set.

To the ignorant and thoughtless this seems a needlessly hard program; as they are not in the habit of undertaking hard tasks, they seldom undertake this one, though it is the only plan that promises success. The weakling allows himself to accept some makeshift device which seems easier, but is likely to fail. Reformation is a long, hard, uphill process, and he who deludes himself with the thought that he can "turn over a new leaf" any time he chooses to do so is making a costly mistake. The older a person

is, the harder is the process of reformation and the greater the likelihood of failure in the attempt.

Reformation must be a self-wrought process. It cannot be imparted from without. No reformatory or other agency outside the offender's own mind can reform a personality. Reformatories and other agencies for reformation may indirectly assist, may prepare for reformation, but they cannot accomplish the reformation. The coöperation and self-denial of the one to be reformed are essential. A high school is a good place in which to prepare for a college education, but it is not a good place in which to acquire the college training. A modern reformatory is well adapted to prepare an offender for the reformation he must plan out and work out for himself, just as the high-school boy plans out and works for his college course. No college student ever got into college who didn't plan to go, determine to go, and then stick to his plan for going for a long time, denying himself the pursuit of pleasure in order to make progress.

Only the well-equipped mentally may hope to succeed in self-reformation. This is a hard fact to face. Lest it should seem that all but normally or supernaturally equipped offenders are debarred from again living worthily because of the difficulties of reformation, we suggest that those of limited mental capacity—those who cannot meet the demands of the above five steps or the demands of society upon them—might be more slowly trained or retrained by being kept for a sufficient length of time in a suitably equipped institution, somewhat like a reformatory, where they would be able to form new and better *habits* of thought and action. In some cases at least we could expect this method to enable restoration to community life. The experience of educators of the feebleminded has shown that habit formation may be depended upon in some cases, deviate in character, to make them capable of returning to their families, after a sufficient term of training.

At present there are no institutions of the kind above indicated for "defective delinquents," but before many years we shall have them. Our laws now sentence those mentally incapable of self-reformation with those capable thereof, and for the short terms adapted only to the preparation of the latter for self-reformation; but eventually our laws will enable the commitment of mental weaklings indefinitely to institutions adapted to their long training in correct habits of thought and action. This will be, probably, the best expedient both for them and for the community.

PSYCHOPATHIC CLINIC OF THE CHILDREN'S COURT OF THE CITY OF NEW YORK

SECOND ANNUAL REPORT*

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DURING the year 1918, the second year of its work, the Psychopathic Clinic of the Children's Court of New York City made a careful mental and physical examination of 1,082 children sent to it from the city's five children's courts. In the Brooklyn clinic, established in the Brooklyn Children's Court, 327 cases were examined. Of these, 305 cases came from the Borough of Brooklyn and 22 from the Borough of Queens. In the Manhattan clinic, 755 cases were examined—684 from the Borough of Manhattan, 63 from the Borough of the Bronx, and 8 from the Borough of Richmond.

To carry on this work, the Manhattan clinic has had the services of one full-time physician, one part-time physician, one psychologist, and two social workers, while the Brooklyn clinic has had one physician on half time, one psychologist, and one social worker. This work was made possible by the generosity of the National Committee for Mental Hygiene.

METHOD OF CHOOSING CASES FOR EXAMINATION

During the year the judges continued to send to the clinic those cases which they recognized as not being normal mentally or as presenting problems which they desired to have carefully studied. The probation officers also brought children who in their opinion needed to be examined. Some cases were received from the Big Brother and Big Sister organizations, and, in Brooklyn, from the Brooklyn Juvenile Protective Association.

The report of the clinic for the year 1917 pointed out the need of work on the problem of recidivism, and during 1918 a detailed study was made of the cases of 268 recidivists, the results of which are stated in a special section of this report.

* Report submitted to the Honorable Franklin Chase Hoyt, Presiding Justice of the Children's Court of the City of New York.

CLASSIFICATION

At the beginning of January, 1918, the clinic adopted a classification for its cases that followed as closely as possible the classification adopted by the American Medico-Psychological Association and used by the National Committee for Mental Hygiene in its Bureau of Statistics. It incorporated in this classification the large group of retarded cases. The classification stands as follows:

1. Normal Group

Of these cases there were 192 or 17.8 per cent.

2. Retarded Group

This group includes those children who are not feebleminded, but who are retarded mentally in consequence of physical defects or poor environmental conditions, such as language defects, lack of opportunity, etc. Of these there were 362 cases or 33.5 per cent. For many of these children with physical defects arrangements were made for treatment in the various hospitals and clinics.

3. Mental Deficiency Group

This group includes:

(a) Morons

Those individuals who are capable of earning a living under favorable circumstances, but are incapable, by reason of a mental defect that has existed from birth or from an early age, of competing on equal terms with their normal fellows or of managing themselves and their affairs with ordinary prudence. Of these there were 304 cases or 28.1 per cent.

(b) Imbeciles

Those individuals who are capable of guarding themselves against common physical dangers, but are incapable, by reason of mental defect that has existed from birth or from an early age, of earning their own living. Of these there were forty or 3.6 per cent.

4. Constitutional Psychopathic Inferiors

This group includes those cases that have a congenital defect in the emotional or volitional fields of mental activity which results in inability to make a proper adjustment to the environment. Of these there were fifty-four or 4.9 per cent.

5. Psychotic Group

This group includes the following psychoses:

Psychoses with mental deficiency
Traumatic psychoses
Toxic psychoses
Juvenile paralysis
Dementia praecox
Manic-depressive psychoses
Undiagnosed psychoses

Of these there were forty-four or 4.1 per cent.

6. Psychoneuroses and Neuroses

This group of cases includes those disorders which are essentially psychogenic in nature. Of these there were sixty-two or 5.7 per cent.

7. Epilepsy

This group includes those cases characterized by attacks in which there is a loss of consciousness with a succession of tonic and clonic convulsions. Of these there were twenty-four or 2.3 per cent.

GENERAL STATISTICAL CONSIDERATION

Of the 1,082 cases examined, 82 per cent were classified in terms of deviation from the normal as follows:

	Total	*Boys*	*Girls*
Mental defectives	344	233	111
Constitutional psychopathic inferiors	54	31	23
Psychotic	44	25	19
Psychoneuroses and neuroses	62	49	13
Epilepsy	24	18	6
Retarded	362	295	67
	890	651	239

AGE

The ages of these children varied from six to sixteen years. There were a few cases brought into court for improper guardianship that were between three and six, and a few over sixteen years that were on probation and had been returned to court for violation of their probation. The age at which the greatest number of boys were arrested was fourteen years, while that of the girls was fifteen years. One of the reasons for this difference

is the fact that girls are less acquisitive than boys, but as they grow older are more prone to become involved in sexual offenses. This is shown more clearly in the table on types of offenses.

ENVIRONMENT

Of the 1,082 cases, 403, or 37.2 per cent, had a favorable environment; 539, or 49.8 per cent, had an unfavorable environment; and in 141 cases, or 13 per cent, the environment was unknown. The percentage of mental deviates having an unfavorable environment was 49 per cent, thus showing that while mental deviates are not inherently criminal, yet when exposed to an unfavorable surrounding, they are unable to resist and tend to become addicted to crime.

NATIVITY

Of the 1,082 cases, 878, or 81.1 per cent, were born in the United States. One hundred and ninety-eight cases, or 18.3 per cent, were foreign born; of this number fifty-three were born in Italy and thirty-nine in Russia. The nativity of six was unascertained.

	Total	*Boys*	*Girls*
Native born	878	646	232
Foreign born	198	139	59
Unascertained	6	6	0
	1,082	791	291

HEREDITY

Of the 1,082 cases, 418, or 38.6 per cent, had an unfavorable family history; 459, or 42.5 per cent, had a favorable family history; 67, or 6.1 per cent, had a doubtful family history; and in 38 cases, or 12.8 per cent, the heredity was unknown. The heredity was considered unfavorable when syphilis, insanity, mental deficiency, epilepsy, tuberculosis, or alcoholism was found among the ancestors. Among the mental deviates, 349, or 40 per cent, were found to have an unfavorable heredity, while among the normal cases 69, or 35 per cent, possessed an unfavorable heredity.

TYPES OF OFFENSE

The offenses in the Children's Court are classified under the two headings "Juvenile Delinquency" and "Special Proceedings."

Under Juvenile Delinquency are grouped all offenses against persons, property, and peace. Under Special Proceedings are the improper-guardianship cases and cases of ungovernable and disorderly children. Of the 1,082 cases, 393, or 36 per cent, were cases of Juvenile Delinquency; 623, or 57 per cent, were cases of Special Proceedings; and 66 were those who did not appear in court.

The cases examined during 1918 showed no increase over 1917 in the number either of improper-guardianship cases or of disorderly children. The number of such cases for 1918 was, in fact, a trifle lower than for 1917.

	Total	*Boys*	*Girls*
Juvenile Delinquency	393	363	30
Special Proceedings			
Improper guardianship	145	80	65
Ungovernable or disorderly children	478	299	179
Others	66	49	17
	1,082	791	291

RECIDIVISM

The following is a brief study of the 268 recidivists who were received for special study during the year 1918.

A recidivist is defined in the Children's Court as a child who has a previous court record. It has long been recognized by criminologists that the repeated offender or recidivist constitutes the most important problem for prisons and reformatories all over the country, and it has been agreed that almost all confirmed criminals show plainly their tendencies by at least late childhood. Therefore, it is in the Children's Court that these repeaters can first be weeded out and efforts made for their readjustment before they have reached the age and condition at which they become a menace to society.

The report of the Special Committee of the State Commission of Prisons shows that 60 per cent of the population of all penal and correctional institutions have served previous commitments, and that in studying chronic criminalism the most important single factor discovered is the abnormal mental condition of the repeaters; 50 per cent of them are mental deviates, of whom 30 per cent are feebleminded.

The 268 children dealt with in the following report were unselected cases, except for the fact that they were recidivists. They

were chosen primarily from the Manhattan court and merely represent a group which the clinic was able to study in addition to its regular cases. They do not by any means constitute the total number of recidivists who passed through the Children's Court during the year 1918.

After examination these cases were classified as follows:

Of the 268 recidivists, 39, or 14.5 per cent, were normal; 110, or 41 per cent, were retarded; 73, or 27.3 per cent, were feebleminded; 18, or 6.7 per cent, were constitutional psychopathic inferiors; 8, or 3 per cent, were psychotic; 17, or 6.3 per cent, were psychoneurotic; and 3, or 1.2 per cent, were epileptic.

The following facts were elicited from a careful study of each group:

Normal Cases

Of the thirty-nine normal cases, thirty-two were boys and seven girls.

(a) Intelligence

In studying their intelligence, the Sanford revision of the Binet-Simon scale was used. According to this scale, the grade of intelligence is expressed by the use of the intelligence quotient (I. Q.) which is the ratio between the mental and the chronological age. The intelligence quotient of thirty-six of these children was between .82 and 1.08, which is reckoned as normal. Two boys and one girl were found to be of superior intelligence, their I. Q. being 1.09, 1.09, and 1.22. The school history of these cases is as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age								
	8	9	10	11	12	13	14	15	16
High School						2	4	1	1
8th grade							3		
7th "					1		4	1	2
6th "				1	1	5	3	2	
5th "				3	1				
4th "			1						
3rd "		1	1						

(b) Heredity

In studying their heredity, it was possible to obtain accurate information for only two generations. Only by the use of careful and intensive field investigation can information be produced by means of which definite conclusions as to the influence of heredity on recidivists can be obtained. However, the following facts are suggestive:

Alcoholism	on	either	paternal	or	maternal	sides in 8 cases
Tuberculosis	"	"	"	"	"	6 "
Insanity	"	"	"	"	"	5 "
Epilepsy	"	"	"	"	"	1 case

In 68 per cent of these 39 mentally normal recidivists nothing definitely unfavorable was found in the heredity.

(c) Environment

It has long been recognized that home conditions are an important factor in determining delinquency, e. g., that the parents are separated or immoral, that there is repeated dissension in the home, that one or both parents are dead. All these conditions enter into the question. The neighborhood, too, has its definite influence; also the financial status of the family—their ability to afford the ordinary necessities for their children—and, in addition, their form of disciplining their children. In 23 cases, or 59 per cent, the circumstances were either comfortable or marginal, the moral influences were good, and the neighborhood fair or good. In sixteen cases, or 41 per cent, the following factors predominated:

In 1 case the father was dead and the mother alcoholic;
" 1 " " mother was epileptic;
" 2 cases " father had deserted;
" 2 " " " was dead and the mother had no control;
" 1 case " " " " " " stepfather cruel;
" 2 cases " mother was immoral;
" 4 " " father was alcoholic and illtreated family;
" 3 " " surroundings were poor.

(d) Physical Condition

Among the seven girls of this group, two were in excellent condition, four had slight defects, and one was suffering from severe valvular heart trouble. Of the boys, sixteen were in excellent condition and sixteen had minor physical defects.

(e) Delinquencies

Of the thirty-nine cases, thirty-two had one previous arrest

four had two previous arrests, two had three previous arrests, one had four previous arrests. Their present arrests were for:

Stealing	21 cases
General incorrigibility	18 "

Their total offenses were as follows:

Stealing	6 instances
Incorrigibility	27 "
Truancy	7 "
Larceny	23 "
Burglary	8 "
Sex immorality	4 "
Robbery	1 instance
Carrying dangerous firearms	1 "

Retarded Group

Of the 110 retarded cases, ninety-four were boys and sixteen girls.

(a) Intelligence

In studying the general intelligence of these cases, they were all found to have an intelligence quotient between .75 and .82, which is reckoned as "dull" or "border line."

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age								
	8	9	10	11	12	13	14	15	16
High School									
8th grade							2		2
7th "						2	5	7	
6th "				1	5	5	9	5	1
5th "				2	3	8	6	3	
4th "			3	8	6	4	2	1	
3rd "			6	4	3				
2nd "	2	3							
Ungraded			1				1		

Of these cases, fifty-six were retarded in their school grade. This condition of retardation was considered as due to physical disabilities, language difficulties, etc. Of this number, for example, seventeen, or 15 per cent, were foreign born and spoke English poorly, and 20 per cent, though native born, came from homes in which a foreign language only was spoken. Thirty, or 27 per cent, had physical defects so severe as to incapacitate them. Sixty-two, or 56 per cent, had each a number of minor defects, which, when taken with language disabilities and poor environment, could account for their retardation. It is, however, this 56 per cent whose mentality cannot be definitely diagnosed without a prolonged period of observation and an improvement of their physical condition.

(b) Heredity

The following facts were obtained concerning their heredity:

Alcoholism on either the paternal or maternal side in 15 cases
Tuberculosis on either the " " " " " 8 "
Insanity on either the " " " " " 8 "
Feeblemindedness on either " " " " " 2 "
Epilepsy on either the " " " " " 3 "

In seventy-two, or 65 per cent, nothing definitely unfavorable was found in the heredity.

(c) Environment

In forty-five cases good surroundings were found and good home influence. In sixty-five, or 60 per cent, the following factors predominated:

In 19 cases the father was alcoholic and the mother worked outside the home;
In 16 cases the father was alcoholic and illtreated the family;
In 3 cases the father was sick and the mother worked to support the family;
In 8 cases both parents were alcoholic;
In 2 cases the mother was immoral;
In 1 case the father was immoral and the mother worked;
In 1 case the mother was insane;
In 2 cases the mother was dead and the father had deserted the home;
In 1 case the mother was dead and the father was immoral;
In 1 case the mother was feebleminded and the father alcoholic;

In 1 case both parents had deserted the home;
In 1 case the father was insane and the mother had deserted;
In 1 case the mother was epileptic;
In 1 case the father was dead and the stepfather illtreated the family;
In 1 case the mother was dead and the stepmother illtreated the family.

(d) Delinquencies

Of the 110 cases, 78 had one previous court record, 21 had two previous court records, ten had three previous court records, and one had four previous court records. Their present arrests were for:

Stealing	50 cases
Arson	2 "
General incorrigibility	58 "

Their total offenses were as follows:

Stealing	22 instances
General incorrigibility	99 "
Truancy	8 "
Larceny	38 "
Burglary	30 "
Assault	11 "
Sex immorality	2 "
Arson	2 "
Robbery	4 "
Peddling	2 "
Discharging firearms	2 "

Mental Defectives

Seventy-three of the recidivists studied were of this group, sixty boys and thirteen girls. Of this number sixty-seven were morons and six imbeciles. No idiots appeared in this group because of the fact that their mental condition is so easily recognized that they are cared for by outside agencies before they become involved in delinquencies.

(a) Intelligence

In this group the I. Q. was found to be below .72. Their school grades were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age							
	9	10	11	12	13	14	15	16
High School								
8th grade								
7th "						1	2	
6th "						4	1	
5th "					3	5	5	
4th "			1	2	2	4	6	1
3rd "		1	1	2	2	3		
2nd "		1	1			1	1	
1st "		1		1	1			
Ungraded	1			2	4	5	7	1

(b) Heredity

The following factors were found in the ancestry of these seventy-three feebleminded cases:

Alcoholism on either the paternal or maternal side in 19 cases

Tuberculosis on either the paternal or maternal side in 9 cases

Syphilis on either the paternal or maternal side in 1 case

Insanity on either the paternal or maternal side in 9 cases

Feeblemindedness on either the paternal or maternal side in 2 cases

Epilepsy on either the paternal or maternal side in 5 cases

In thirty-four cases, or 46.6 per cent, nothing unfavorable was found in the heredity. It is considered that the majority of these thirty-four cases are suffering from secondary amentia, brought on by accidents, birth paralysis, or severe illness, and, therefore, not inheritable. In twenty of these cases such causes were elicited in the history. The others are doubtful cases, and the cause of their mental defects cannot be proved without more intensive study.

(c) Environment

In only 20 cases, or 27.4 per cent, were the surroundings and influences favorable.

In 53 cases, or 72.6 per cent, both the surroundings and influences were bad;
In 21 cases the father was alcoholic;
In 8 cases the mother worked and there was no supervision;
In 6 cases both parents were alcoholic;
In 1 case the father was alcoholic and the mother feebleminded;
In 1 case the father was feebleminded and the mother alcoholic;
In 1 case the father was alcoholic and the mother immoral;
In 1 case the father was alcoholic and the mother epileptic;
In 1 case the father was alcoholic and syphilitic;
In 1 case the father was alcoholic and tubercular;
In 1 case the father was alcoholic and the mother dead;
In 4 cases the father was abusive;
In 1 case the father was epileptic;
In 1 case the father was dead and the mother epileptic;
In 3 cases the father was dead and the mother worked;
In 1 case the father was immoral;
In 1 case the mother was alcoholic.

(d) Physical Condition

Thirty of the children, or 41 per cent, were in excellent physical condition, 42 per cent had some minor defects, and only 17 per cent had serious physical defects, including depressed fractures of the skull, chorea, valvular heart trouble, and tuberculosis.

(e) Delinquencies

Of the seventy-three cases, forty-six had one previous court record, eleven had two previous court records, seven had three previous court records, seven had four previous court records, and two had five or more previous court records. Twenty-four per cent of the feebleminded recidivists had four or more arrests, while only 8 per cent of the normal cases were recidivists with an equal number of arrests.

This high percentage of recidivism among the feebleminded shows that whereas a feebleminded individual is not inherently a criminal, nevertheless, when exposed to temptation in a poor environment, he becomes more easily a member of the criminal class than does a normal individual. The latest delinquencies of the members of this group were as follows:

General incorrigibility	40 cases
Stealing	28 "
Assault	3 "
Immorality	2 "

Their total offenses were as follows:

General incorrigibility	79 instances
Larceny	24 "
Burglary	20 "
Stealing	9 "
Immorality	5 "
Robbery	2 "
Truancy	5 "
Assault	2 "

Constitutional Psychopathic Inferiors

Of the eighteen constitutional psychopathic inferiors, fourteen were boys and four were girls.

(a) Intelligence

It was found that the I. Q. ranged between .85 and 1.00. There were no cases of superior intelligence and none that were suggestive of a border-line condition.

Their school history is as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age						
	9	10	11	12	13	14	15
High School							1
8th grade						1	3
7th "					1	2	
6th "						4	1
5th "				1			
4th "	1			1			
3rd "		1					
2nd "							
1st "							
Ungraded						1	

(b) Heredity

In studying their heredity, the following factors were found:

Alcoholism on either the paternal or maternal side in 7 cases
Tuberculosis " " " " " " " 1 case
Insanity " " " " " " " 2 cases

In 44 per cent there was nothing definitely unfavorable in the heredity.

(c) Environment

In only five cases, or 27.8 per cent, were the surroundings and influence favorable. In four cases both the surroundings and influences were unfavorable. In thirteen cases, or 72.2 per cent, the following factors predominated:

In 5 cases the father was alcoholic;
In 3 cases the father was alcoholic and abusive;
In 1 case both parents were alcoholic;
In 2 cases the father was dead and the mother worked;
In 1 case the father deserted and the mother was insane;
In 1 case the father was dead and the stepfather abusive.

(d) Physical condition

Thirteen of these children, or 72 per cent, were in excellent physical condition. Two had minor defects, and three were in poor physical condition.

(e) Delinquencies

As the trouble of the constitutional psychopathic inferior group lay in the emotional and volitional fields, their conduct was usually an expression of this condition.

Of the eighteen recidivists, ten had one previous court record, five had two previous court records, and two had more than five court records. Their latest delinquencies were as follows:

General incorrigibility	11 cases
Stealing	6 "
Arson	1 case

Their total offenses were as follows:

General incorrigibility	27 instances
Larceny	7 "
Burglary	6 "
Stealing	7 "
Truancy	2 "
Assault	5 "
Arson	2 "

Of the fifty-four offenses committed by these eighteen individuals twenty-seven, or 50 per cent, were for general incorrigibility. This term is used to express such delinquencies as staying away from home, insubordination to parents, small thefts, occasional truancy. The group of constitutional psychopathic inferiors comprises those individuals who are unsuccessful in the environment in which they are placed and whose delinquencies, while not often serious, are usually frequently repeated and finally cause an appearance in court. In two cases the children had been brought to court six times each. One case, a boy of fourteen years, while fairly intelligent, was so unstable that he had been unable to adjust himself in any class at school and had finally been placed in a special class. His delinquencies were as follows—none of them very serious:

Deserted his home
Deserted his home
Stole a baby carriage
Deserted his home
Found with a pair of stolen skates
Truancy
Insubordination in his home
Truancy—committed to truant school
Truancy on release from truant school.

The other case, also a boy of fourteen, had the following record:

Stealing automobile tools
Insubordination in the home
Throwing stones
Throwing stones in a street fight
Striking teacher in school
Truancy.

The homes of both of these boys were not such as to encourage an attempt at readjustment, even with intensive supervision, and both boys were, therefore, placed in an institution.

Psychoneuroses

Of this group there were seventeen—two girls and fifteen boys.

(a) Intelligence

In studying the intelligence of this group, the I. Q. was found to be between .90 and 1.00.

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age						
	9	10	11	12	13	14	15
High School							4
8th grade						2	3
7th "						1	
6th "			1	1		1	
5th "			1	1			
4th "	1		1				

Of these seventeen cases, six were of the psychasthenic type. In these cases there were present phobias, obsessions, and morbid doubts. Ten were anxiety neuroses, consisting of nervous irritability, anxious expectation, and dread. Most of these cases had, in addition, cardiac and circulatory disturbance. One was a neurasthenic who suffered from mental and motor fatigue.

(b) Heredity

The following factors are suggestive in their heredity:

Alcoholism on either the paternal or maternal side in 7 cases
Tuberculosis " " " " " " " 3 cases
Syphilis " " " " " " " 1 case
Insanity " " " " " " " 3 cases

Only in three cases, or 17 per cent, was nothing unfavorable found in the heredity.

(c) Environment

Four cases, or 24 per cent, had good surroundings and good home influence. In thirteen cases, or 76 per cent, the following factors predominated:

In 6 cases the father was alcoholic;
In 1 case both parents were alcoholic;
In 1 case father was alcoholic and the mother neurotic;
In 1 case the father was a criminal and alcoholic and the mother was alcoholic;

In 2 cases the father was a gambler and the mother alcoholic;
In 1 case the father was insane and the mother worked;
In 1 case the mother was immoral.

(d) Physical Condition

In ten cases the children were in excellent condition. In seven cases there were minor physical defects, such as cardio-vascular disturbance with neurological symptoms.

(e) Delinquencies

Of these seventeen cases, twelve had had one previous court record, four had two previous court records, and one had had three previous court records. Their latest delinquencies were as follows:

General incorrigibility	16 cases
Arson	1 case

As in the case of the constitutional psychopathic inferiors, their delinquencies were usually not serious and were generally due to their instability and lack of power to adjust themselves to their environment.

Their total offenses were as follows:

General incorrigibility	33 instances
Larceny	3 "
Arson	1 instance
Truancy	1 "
Burglary	4 instances
Assault	1 instance

Psychotic Cases

Of these eight cases there were two of juvenile paralysis, one of traumatic psychosis, and five of undiagnosed psychoses.

(a) Intelligence

In studying the intelligence of this group, the I. Q. was found to be between .95 and 1.10 in the undiagnosed psychoses, and between .80 and .90 in the other cases.

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age								
	7	8	9	10	11	12	13	14	15
High School									2
8th grade									1
7th "									1
6th "									
5th "					1				
4th "			1			1			
Ungraded	1								

(b) Heredity

The following facts are suggestive in their heredity:

Alcoholism on either the paternal or maternal side in 4 cases
Syphilis " " " " " " " " 1 case
Insanity " " " " " " " " 3 cases
Epilepsy " " " " " " " " 1 case

In none of the cases was a favorable heredity found.

(c) Environment

In only one case were the surroundings and home influence good;

In 3 cases the father was alcoholic;
In 2 cases the mother was insane;
In 1 case the father was alcoholic and the mother insane;
In 1 case the mother was syphilitic and immoral.

(d) Physical Condition

The general physical condition of all these cases was poor.

(e) Delinquencies

Of the eight cases, six had one previous arrest and two had two previous arrests. Their latest delinquencies were as follows:

General incorrigibility..... 7 cases
Stealing..... 1 case

Their total offenses were as follows:

General incorrigibility..... 12 instances
Larceny..... 1 instance
Vagrancy..... 1 "

Stealing	1 instance
In danger of becoming immoral	1 "
Selling newspapers without a license	1 "

In these cases the mental condition was so serious that they were early recognized and brought up for examination before their delinquencies had become marked.

Epilepsy

This group was composed of three boys only.

(a) Intelligence

In all of these cases there was some mental deterioration. The intelligence quotient was between .70 and .80.

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age			
	11	12	13	14
High school				
8th grade				
7th "				
6th "				
5th "				1
4th "	1	1		

(b) Heredity

Their heredity was as follows:

Alcoholism on either the paternal or maternal side in 2 cases
Epilepsy " " " " " " " " 1 case
Tuberculosis " " " " " " " " 1 "
Insanity " " " " " " " " 1 "

In none of these cases was the heredity favorable.

(c) Evironment

Their environment was as follows:

In 2 cases the father was alcoholic;

In 1 case both the surroundings and the moral influences were good.

(d) Delinquencies

Each of the three cases had only one previous court record, due, probably, to the fact that epilepsy is easily recognized and that, like the psychotic, epileptics are immediately brought for examination.

Their present offenses were:

Stealing	3 cases

Their total offenses were:

Larceny	4 instances
Burglary	1 instance
Robbery	1 "

Conclusion

It is a well known fact that it is the recidivist who presents the real problem in criminology. The most advantageous place to begin a study of recidivism is in children's courts with preadolescent children.

In studying the 268 cases of recidivists, we discovered, first, that 82.9 per cent of these recidivists, with one previous court record, were mental deviates, and 24.5 per cent of this number were feebleminded; second, that 91.6 per cent of these recidivists, with two previous court records, were mental deviates, and 22.9 per cent of this number were feebleminded; third, that 90.9 per cent of these recidivists, with three or more previous court records, were mental deviates, and 48.5 per cent of this number were feebleminded.

In addition to the fact that mental deviation is found in such a high percentage of recidivists, it is well recognized that many criminal careers are due to the repeated exposure of these individuals to unfavorable environmental conditions. Among the cases brought to the clinic this aspect of the situation was found to stand out unmistakably. Of the recidivists studied, 170, or 63.4 per cent, were found to have an unfavorable environment.

In the light of these facts, constructive work for the prevention of recidivism should be initiated along these lines: changing or improving the environment of first offenders, and recognizing and—as far as possible—segregating mental deviates.

NOTES AND COMMENTS

District of Columbia

A division in the Bureau of Education for the study of the educational needs of mentally handicapped school children is provided for in H. R. 8479, recently introduced in Congress. The work of this division would include the following: "First, the collection, tabulation, interpretation, and publication of the results of tests useful for mental and educational classification, and of information bearing on the organization and conduct of the work undertaken in the schools of this country and elsewhere for feebleminded, backward, and otherwise mentally exceptional children. Second, the conduct of a laboratory of mental tests and standards for the development and standardization of mental tests and standards of mental capacity for normal children of different ages, said tests and standards being essential for the diagnosis and classification of mentally subnormal and abnormal school children and juvenile and adult delinquents. Third, the conduct of a psycho-educational clinic for the examination and classification of mentally defective school children from the District of Columbia or elsewhere." This division of the Bureau of Education would have its own director, to be appointed by the Commissioner of Education, at a salary of $4,500. The bill would provide $30,000 annually for the maintenance of the division.

Iowa

A state psychopathic hospital is authorized by Chapter 235, Laws of 1919. It is to be located at Iowa City in connection with the College of Medicine of the State University of Iowa, and is to be under the control of the State Board of Education. The professor of psychiatry of the college is to be the medical director of the hospital. Provision is made for the admission of both committed and voluntary patients and for their discharge by the medical director when improved or unlikely to be benefited by further treatment. Any patient may be transferred by the medical director to a state hospital for mental diseases when, after a satisfactory period of observation, further treatment at the psychopathic hospital seems inadvisable. The act carries an appropriation of $175,000 for the erection and equipment of the hospital, and the cost of its maintenance is to be borne by the state.

Chapter 366, Laws of 1919, is an act to abolish the State Hospital for Inebriates, at Knoxville. The State Board of Education and Board of Control are to confer together upon the disposition of the hospital and to report at the next session of the legislative assembly what best use

may be made of it. The one at Willmar, Minnesota, which was opened in December, 1912, was discontinued by legislative enactment in 1917. The Norfolk (Mass.) State Hospital, which was opened in June, 1914, to receive alcoholics and drug addicts, became U. S. Army General Hospital, No. 34, and has more recently been taken over by the United States Public Health Service for the treatment of epileptics. This leaves the State Farm for Inebriates, at Preston, Connecticut, the only state institution caring exclusively for this class of patients.

The Institution for Feebleminded Children, at Glenwood, has received from the 1919 legislature $35,000 for the construction and equipment of a bakery. The sum of $31,600 has been granted the Independence State Hospital for the completion and equipment of a power house. The State Hospital and Colony for Epileptics, at Woodward, has been granted for new construction the sum of $24,250.

Louisiana

The Milne Home and School for Girls, at New Orleans—an industrial home for feebleminded women—was opened August 18. A department for boys is also contemplated in the near future. The Louisiana Committee on Provision for the Feebleminded last year secured the passage of a law authorizing the commitment of mental defectives to licensed private institutions and making a small initial appropriation for that purpose. Subsequently, a citizen of New Orleans built a school for the feebleminded and put it under the City Poor Department of New Orleans. This department has agreed to begin operation as soon as there are sufficient funds available. In the meantime, feebleminded girls will be cared for at the Milne School.

Massachusetts

The school for the feebleminded at Belchertown, which was authorized by the 1915 legislature, has received an appropriation of $250,000 which will provide for the erection of a storehouse, bakery, laundry, power house, custodial building, dormitory, and road construction.

Nebraska

For additions and improvements at the Nebraska Institution for Feebleminded Youth, $126,000 has been appropriated by the 1919 legislative assembly. The Ingleside Hospital for the Insane received $144,500; the Nebraska Hospital for the Insane, at Lincoln, $14,000; and the Hospital for the Insane of Nebraska, at Norfolk, $127,250 for construction and improvements.

Nevada

The Nevada Hospital for Mental Diseases has received an appropriation of $190,000 for the construction of a new building.

New Jersey

The 1919 legislature has granted an appropriation of $400,000 to the New Jersey State Hospital at Morris Plains for the erection of two "treatment buildings for the prevention and curing of insanity." The State Institution for Feebleminded has received an appropriation of $135,000 for the construction of new buildings. For the purchase of additional farm land the sum of $11,000 has been granted by the legislature to the Village for Epileptics.

New Mexico

The New Mexico Insane Asylum has received from the 1919 legislature the sum of $122,000 for new construction.

New York

The State Commission for Mental Defectives in its report to the governor and the 1919 legislative assembly proposed the state-wide establishment of clinics for the diagnosis and treatment of mental diseases and defects. These clinics would coördinate well with the proposed health centers which the Department of Health is to establish throughout the state. Clinics for mental patients have been maintained by the state hospitals for a number of years and there are at the present time over thirty such clinics. There is need, however, for clinics throughout the state for the mental examination of persons thought to be mentally deficient and plans are now under way for the establishment of these clinics by the State Commission for Mental Defectives.

Plans are being made by the Hospital Development Commission for a state psychopathic hospital in New York City. This hospital will not only provide temporary care for incipient cases of mental disorder, but will be a research department of the state hospitals for scientific study into the causes of mental disease. The plans call for a hospital of 200 beds.

Work has begun on the new state hospital for mental diseases, at Marcy, for the construction of which $2,000,000 has been appropriated. When completed, this hospital will care for 3,000 patients. It will be a division of the Utica State Hospital, from which it is six miles distant. The last hospital for mental diseases erected by New York State was the one at Gowanda in 1898.

North Carolina

The land and buildings of the State Prison and State Hospital for the Dangerous Insane, located at Raleigh, are to be transferred to the State Hospital at Raleigh, in accordance with Chapter 63, Laws of 1919. Patients from the other state hospitals will be removed to this one as soon as the prisoners can be accommodated elsewhere. All negroes

cared for at present at the State Hospital for Dangerous Insane will be removed to the State Hospital at Goldsboro as soon as the necessary accommodations can be provided at this hospital for them.

Ohio

Among recent appropriations made by the legislature are $220,000 to the Columbus State Hospital, for five new cottages, $90,000 for the Ohio Hospital for Epileptics, at Gallipolis, and $20,000 each for a hospital for tuberculous patients at the Athens State Hospital and Massillon State Hospital.

Oregon

The sum of $54,000 has been granted the State Institution for the Feebleminded by the 1919 legislature for the construction of two additional dormitories.

Voluntary admission to the state hospitals for mental diseases is authorized by Chapter 125 of the Laws of 1919. According to this law, the superintendent may receive as a patient, for a period not to exceed one month, any person suffering from "nervous diseases threatening mental disorder," upon his written application, provided his mental condition is such as to render him competent to make such application. A patient thus received must not be detained more than thirty days after having given written notice of his desire to leave the hospital. The application may be renewed at the end of one month; but no application shall be effective unless signed in the presence of a friend and also of a medical attendant.

A joint resolution of the last legislative assembly extended to The National Committee for Mental Hygiene an invitation to conduct a survey of the care and treatment of the insane in Oregon. The State Board of Control has been authorized to appoint a committee of three women and three men, who are residents of the state, to coöperate with the National Committee in making the necessary observation and investigation.

Pennsylvania

Four new buildings are to be constructed at the Homeopathic State Hospital, at Allentown, at a cost of over $75,000. The contract for construction has been awarded and will include a home for women nurses, a nurses' dining room, employees' sleeping quarters, and a farmhouse.

South Carolina

The State Training School for Feebleminded, whose establishment was authorized in 1918, has received from the 1919 legislature an additional sum of $57,866.38. The buildings at the school are to be of fireproof construction and are to be erected on the cottage plan.

The State Hospital for the Insane, at Columbia, has been authorized to expend $150,000 for development and repairs.

A resolution was passed by the 1919 legislature to have the laws relating to the state hospital for mental diseases studied thoroughly by a committee composed of a senator, to be appointed by the President of the Senate, and two members of the House of Representatives, to be appointed by the Speaker of the House. It is believed that a complete revision of these laws would be of material benefit to the hospital and its patients. At the next session of the legislature this committee is to make a report and suggest such changes as seem desirable.

South Dakota

The 1919 legislature has appropriated $10,000 to the Home for Feebleminded, at Redfield, for the purchase of additional land, and $151,000 for new construction and furnishings; $20,000 for improvements to the grounds of the new state hospital for mental diseases at Watertown; $133,000 for new construction and improvements at the Yankton State Hospital, and $125,000 for additional land at this hospital.

Texas

The Northwest Texas Insane Asylum has been granted an appropriation of $350,000 for further construction. This appropriation is in addition to the one made in 1917, when the hospital was authorized. At that time $400,000 was appropriated. Later Wichita Falls offered a free site of 500 acres and free water supply, which offer is estimated to be worth $100,000. This hospital will care for white insane patients, the colored patients being provided for at the hospital at Rusk, authorized in 1917. Texas maintains three other hospitals for mental diseases.

Dependable Statistics on Mental Diseases

In spite of the fact that the total number of beds in hospitals for mental patients in the United States exceeds the number in general hospitals, very little reliable statistical information is available concerning the prevalence, causes, treatment, and prevention of mental diseases. Reports of hospitals caring for mental patients give many details with reference to administrative and financial problems and much information relative to the farms and gardens and the products of the dairies, piggeries, and henneries. In marked contrast with these illuminating details are the meager data with reference to the patients.

One of the primary causes of this lack of information has been the absence of a well-devised system of recording and classifying observations in hospitals that treat mental patients. Until recently there existed in this country no generally accepted classification of mental diseases nor even a uniform system of recording data concerning admissions, recoveries, and deaths of patients. Classifications used in some states were

similar in many respects, but differed just enough to prevent their use for cumulative or comparative purposes.

Realizing the need of a standard nomenclature of mental diseases and a uniform statistical system for the use of hospitals for the insane, the American Medico-Psychological Association, at its annual meeting in June, 1913, appointed a committee to consider this matter and to devise ways and means for improvement. This committee held several conferences, consulted experts, appointed subcommittees to consider various phases of the work, and gave the whole matter very careful study. Its first efforts were directed toward the preparation of a classification of mental diseases that would meet the demands of modern psychiatry and at the same time be acceptable to the hospitals for mental diseases in this country.

After the final report of this committee—which set forth the need of better statistics of mental diseases and recommended a nomenclature and statistical system—was submitted to the Association in May, 1917, and unanimously adopted, a standing Committee on Statistics was appointed to promote the introduction of the system throughout the country. This committee invited The National Committee for Mental Hygiene to coöperate in the work.

With an appropriation from the Rockefeller Foundation for the purpose, the National Committee, through its Bureau of Statistics, began work in this special field in February, 1918. The first step consisted in submitting the classification and the outline of the statistical system to the superintendents of state hospitals for mental diseases. Later a manual was prepared containing definitions and explanations of the terms used in the classification, suggestions for the diagnosis of the various clinical groups, and directions for the preparation of annual statistics. This manual and a series of eighteen standard statistical forms were supplied without charge to all coöperating hospitals. Within a year, 145 of the 156 state hospitals in this country, together with a number of city, county, and private hospitals that care for mental diseases, have signified their willingness to follow the new classification. These comprise all the state hospitals in forty states, and some in all but three of the others. The new system has also been adopted by the federal hospital for the insane and by the Division of Neurology and Psychiatry in the office of the Surgeon General of the United States Army. Published reports containing data prepared according to the uniform system are being received and show a marked improvement over those issued in previous years. Very recently the American Association for the Study of the Feebleminded has appointed a Committee on Uniform Statistics to coöperate with the Committee of the American Medico-Psychological Association and The National Committee for Mental Hygiene. It is practically certain that the fifty state institutions for the mentally de-

fective and the epileptic will soon be added to those employing the forms adopted.

In order to promote efficiency in the statistical work of the various institutions, standard sets of record cards have been prepared and distributed at cost to all hospitals requesting them. These cards, when properly filled in, contain all the information called for on the tabular forms and facilitate the compilation of annual statistics. At the present time, they are being used in over fifty hospitals, and more than 50,000 cards have thus been distributed.

The Bureau of Statistics of The National Committee for Mental Hygiene is now engaged in the preparation of a review which is planned to give a summary of general information, financial operation, and movement of population of the various state hospitals in the country. Since many of the hospitals did not begin to use the classification until late in 1918, the preparation of a statistical review with complete reports from state hospitals will have to be deferred for a time.

In attacking any problem, it is first essential to know its size. The adoption of the new classification and uniform statistical system will make it possible to obtain information concerning the prevalence of the various types of mental disease in hospitals throughout this country. Further, accurate data will also be possible with reference to the causes of insanity, the frequency of its different forms, relation of sex, age, race, occupation, and climate to the several psychoses, duration of hospital residence, recovery and death rates, etc., through careful study of the annual statistics prepared by the hospitals in accordance with the standard uniform system. The fact that on January 1, 1918, there were 239,820 patients in public and private hospitals for the care of the insane in the United States* is sufficient proof that there is no lack of material for such studies. In addition to the great amount of information unquestionably needed that may be thus secured, the adoption of this classification of psychoses throughout the United States will do more toward promoting the standards of scientific accuracy in the field of mental medicine than anything heretofore attempted or even proposed.

War Neurosis in the Battle of Marathon

"Is this, perchance, the first account of 'shell-shock'?" queries Dean A. Worcester in a recent letter to the editor of *Science*. Dr. Worcester quotes Herodotus, describing the battle of Marathon, 490 B.C. (Book VI., section 117):

"The following prodigy occurred there: an Athenian, Epizelus, son of Cuphagoras, while fighting in the medley, and behaving valiantly,

* Annual Census of the Insane, Feebleminded, Epileptics and Inebriates in Institutions in the United States, January 1, 1918. By Horatio M. Pollock, Ph.D., and Edith M. Furbush, A.B., B.S. Mental Hygiene, 2:78–107, January, 1919.

was deprived of sight, though wounded in no part of his body, nor struck from a distance; and he continued to be blind from that time for the remainder of his life. I have heard that he used to give the following account of his loss. He thought that a large heavy-armed man stood before him, whose beard shaded the whole of his shield; that this specter passed by him, and killed the man that stood by his side. Such is the account I have been informed Epizelus used to give."

Harrisburg Mental Hygiene Clinic

In November, 1918, the Mental Hygiene Committee of the Public Charities Association of Pennsylvania organized a mental hygiene clinic at Harrisburg under the general direction of Dr. W. E. Wright, formerly a member of the staff of the Harrisburg State Hospital. A preliminary report of the first few months' work of the clinic shows most interestingly not only the need for such a clinic in the vicinity in which it is established, but the extent to which neighboring communities reach to it for assistance. While the majority of patients attending the clinic came from Harrisburg, patients were brought, also, from sixteen cities and towns in the vicinity.

Psychological Clinic in Louisville, Kentucky

In Louisville, Kentucky, there has been established a psychological clinic which stresses the intimate relation between organized social service and mental hygiene. This clinic is under the joint control of the board of education and the Louisville Welfare League. Under the latter orgainzation are federated the social agencies of Louisville. These agencies refer cases in which mental trouble is suspected to the clinic for examination. In addition the clinic is at the service of the juvenile and police courts of Louisville. In the latter, as a matter of routine, the clinic is examining all infected women quarantined by the venereal clinic.

Surveys are being made of the various institutions, such as the orphanages, reformatories, etc., to identify mental defect among the inmates.

The importance of determining the presence of mental defectives and psychopaths among the inmates of child-placement institutions needs no emphasis. Defective children should not be recommended to homes where they will be given care and training of which a normal child might take advantage. The Louisville clinic examines all the admissions to the Kentucky Children's Home Society.

In the public schools, special classes for superior children—called "opportunity classes"—and atypical classes for mentally retarded and defective children have already been established. The staff of the clinic examines candidates for these classes.

Group tests of mentality have made possible the testing of large

numbers of individuals at one time. A mental survey of the Louisville schools is projected under the direction of the clinic staff.

Henrietta V. Race, Psychologist of the Louisville Public Schools, is director of the clinic. Frank S. Fearing, recently in charge of the psychological examinations in the Psychiatric Division at the U. S. Naval Training Station, Hampton Roads, Va., is the assistant director. Associated with the clinic are two psychiatrists, Dr. W. E. Gardner and Dr. H. B. Scott. They are on the staff of the Louisville City Hospital, and thus are able to place the psychopathic ward of that institution at the service of the clinic.

Mississippi Society for Mental Hygiene

A meeting was held in the rooms of the Jackson Board of Trade, Jackson, Mississippi, August 15, 1919, for the purpose of organizing the Mississippi Society for Mental Hygiene. Dr. C. D. Mitchell, Superintendent of the Mississippi State Insane Hospital, was elected temporary chairman, and Dr. J. H. Fox to serve as secretary. The following resolutions were passed:

That it is the sense of this meeting that a State Society for Mental Hygiene, to be affiliated with The National Committee for Mental Hygiene, shall be organized in Mississippi, and that it shall be known as the Mississippi Society for Mental Hygiene.

That the chairman of this meeting shall appoint a temporary organizing committee of not fewer than seven or more than fifteen members, which shall have power to adopt a constitution and by-laws, and appoint not more than two-thirds of the members of the original board of directors, who, upon call of the temporary organizing committee, shall meet and perfect the organizing of the Mississippi Society for Mental Hygiene by formally adopting the constitution and set of by-laws and by electing such officers, et al., as may be provided for in the by-laws.

That this temporary organizing committee shall have power to take any other action for the society which it shall deem expedient.

It is proposed to have a larger meeting and effect permanent organization in October, when the Mississippi State Fair will be held in Jackson and there will be a state meeting of the American Legion.

Those who attended the organization meeting were: John L. Green, Superintendent, Mississippi Children's Home Society, Jackson, Mississippi; J. H. Fox, M.D., formerly Assistant Superintendent, Mississippi State Insane Hospital, now in private practice, Century Building, Jackson, Mississippi; C. D. Mitchell, M.D., Superintendent, Mississippi State Insane Hospital, Jackson, Mississippi; Mrs. Arthur Granberry, Member of the Mississippi Mental Hygiene Commission; Herschel Brickell, Associate Editor of the *Jackson Daily News*; Kate Markham Power, formerly of the *Jackson Daily News*, and

lately W. C. C. S. Representative at Camp Sheridan, Montgomery, Alabama; Marcia Gibbs, Principal, Poindexter School, Jackson, Mississippi; J. R. Carter, Superintendent, Baptist Orphanage, Jackson, Mississippi; and Thomas H. Haines, M.D., Scientific Adviser to the Mississippi Mental Hygiene Commission.

The Week's Meeting on Criminal Law

Editorial, *The Boston Herald*

The people of Massachusetts are probably as peaceable as those of most states, yet it is necessary to have seventy-five courts to settle our controversies. Some of these are between citizens, over matters of business. The state is intolerant of these. It has created tribunals to adjust them, and it compels the parties to accept their decisions. There are also controversies between the state and its own citizens. Well-nigh 200,000 of them break its laws every year. The state settles these controversies, also, and compels the adverse party to accept its decision.

Most of the state agencies which deal with social problems have the future in view, in their work, but the courts are peculiar in this—that on the "civil" side they deal with past transactions, and on the criminal side with past actions. In settling business controversies the state takes action in order that business may go on. In disposing of criminal cases its aim is to prevent lawlessness by compelling the offenders to accept its standards. In this it succeeds only partially.

Within a few years the courts have changed their views and purposes radically. They have come to see that little has been accomplished, and that little can be accomplished, under a system which deals only with the past of a wrongdoer. To find, on the evidence, that on a certain day a man violated a law of the state, and to impose a penalty for that past act, "making it fit the crime," leaving the offender with an unchanged purpose, ready to commit another crime, was a waste of a large part of the effort expended.

The changes in the methods of modern courts for criminal business have been made with the purpose of centering the attention of the offender on his future, rather than on his past. To do this the state sets an example, by considering the crime mainly as an indication of the character of the criminal, and of the treatment needed to readjust him in society as a good citizen. They aim to make this treatment fit the individual criminal, rather than his crime, which necessitates new methods, new machinery, and a new spirit.

The men who, ten years ago, formed the American Institute of Criminal Law and Criminology, which will hold its eleventh annual meeting in this city this week, beginning on Tuesday next, saw that these changes in the direction of the efforts of the criminal courts, if they were to be made wisely, must be accomplished by the coöperation of many intelli-

gent, progressive, well-balanced men. The declared object of the institute is "to further the scientific study of crime, criminal law and procedure; to formulate and promote measures for solving the problems connected therewith, and to coördinate the effort of individuals and of organizations interested in the administration of certain and speedy justice."

Sometimes

You can't educate a grasshopper. He's too busy hopping. The peculiarity of man is that sometimes you can induce him to stop and think.—Samuel McChord Crothers, *Atlantic Monthly*, September.

The Scandal of Euclid: A Freudian Analysis, by Simeon Strunsky, in the *Atlantic Monthly* for September, which purports to be a review of a book, *Sex Elements in the First Five Books of Euclid*, will be of interest to students of pyschoanalysis.

Appealing to Brains Diseased

Editorial, *The New York Herald*

Institutional and public correctional authorities having to do with delinquent children have not been satisfied entirely with the result of the approved methods for the education of their charges even when those methods have been thoroughly understood and conscientiously followed. Prior to 1825 all juvenile offenders of both sexes were housed and cared for along with adult criminals. Those schools of iniquity long ago gave way to separate institutions for boys and girls, from which the country has greatly benefited, but which, it seems, are not yet conducted on a system from which the best results may be obtained. Too often the outcome is antisocial reaction in adolescence, to end in careers of crime or worthlessness.

Recent studies by the United States Public Health Service of the mental condition of the inmates of private and state schools for such children have shown that a far greater number of the inmates than is generally supposed to be the case—about 11 per cent—are under average mental development or suffer from some form of psychic disturbance. Little difference is observed between such children and those of more normal mind in the grouping for class work. The present training system does not recognize the need of it. Dr. W. L. Treadway in a report holds that it is impossible to reform these afflicted little ones because they cannot respond to such efforts. He urges special and individual care in such cases.

This problem is one that should be given serious attention. Public Health Service officials strongly urge that a psychopathologist be placed on the staff of every correctional institution and made a part of every juvenile court. They argue these measures would tend to a better understanding of the psychopathic child, insure a more promising

grouping of delinquents, and assure the proper disposition of particular cases. The conclusion of the investigating medical officer is that mental disorders must be taken into account in trying to reform youthful prisoners committed to beneficent institutions rather than to jail.

Ordinances for the Control of Venereal Disease

For the benefit of cities that wish to enact legislation looking toward the control of venereal diseases, the United States Public Health Service, aided by the Law Enforcement Division of the War Department, has prepared a compilation of ordinances that have been found successful in the campaign against these diseases. Among them are ordinances dealing with the licensing of hotels, rooming houses, dance halls, and public vehicles, and with the regulation of restaurants, etc., and prohibiting the advertisement of venereal disease "cures" or the sale of venereal disease medicines except on prescription. Each of these ordinances has been put into effect in various cities with satisfactory results. Cities that wish to adopt similar legislation are advised to consult competent legal authority as to the changes necessary to meet constitutional and charter requirements.

The index for Volume III of MENTAL HYGIENE will soon be ready. Subscribers who wish a copy of this index will be supplied with it upon written request.

ABSTRACTS

The War Neuroses as Physiologic Conservations. By Sidney I. Schwab, M.D. *Archives of Neurology and Psychiatry*, 1: 579–635, May, 1919.

The problem presented by the war neuroses to the A. E. F. was in one respect essentially different from that with which any of the allied armies had to deal. Both the French and the British were comparatively near their home bases and could utilize for patients suffering from war neuroses practically all the medical resources of their respective nations. For the A. E. F. transportation difficulties made this impossible; they had to handle such cases on foreign soil at or near the actual zone of fighting. In consequence, while they were able to take advantage in many ways of the experiences of other nations, they had to evolve a system of treatment adapted to their own peculiar circumstances. The result, briefly put, was the system centering around Base Hospital 117 at LaFauche, of which Dr. Schwab, the author of the present article, was medical director. And a further result—and one more important in its bearing on peacetime problems—was the development of what Dr. Schwab calls "the A. E. F. point of view." It is this point of view that Dr. Schwab is particularly interested in explaining, with the idea of its applicability "to the same kind of problems, less dramatized perhaps, which have been so common in times of peace."

The A. E. F. point of view was largely determined by the conception of the war neuroses held by Colonel Salmon—the senior consultant in neuropsychiatry—and some of the chiefs of departments under him. The war neuroses, in their opinion, were an aspect of a primitive defense mechanism designed to protect the human organism against the injurious or unpleasant incidents of warfare—a defense mechanism that "inserted itself automatically between the soldier and a repetition of the same or similar incidents which in the first place caused the soldier to react as a war-neurosis case. As a result of this view, formulated early enough to make it a part of the general scheme of treatment and organization, war neuroses were recognized as very real conditions, one to which any soldier, given a succession of etiologic incidents, might fall a victim. In this way, also, the soldier could be viewed objectively and dispassionately in relation to his neurosis and the same method could be followed as is in vogue in the study of the many types of infections and other diseases to which a soldier in the performance of his duty is subject.

"The question of the soldier's participation in the formation of his neurosis, how much conscious effort went into it, the rôle of exaggeration and malingering and other confusing incidents, might then be made the

object of legitimate inquiry, uninfluenced by preconceived notions in respect to courage, bravery, wish, desire, cowardice, etc."

The problem of the war neuroses has three main aspects. In the first place, there is the military. "This concerns itself with the important fact that the soldier with war neurosis is, in most instances, physically intact and very often in splendid physical condition. . . . He obviously cannot be classified as mentally unfit, nor can he be regarded as physically disabled, yet he is incapable in this state of acting the part of a soldier. The fact that he has, at times, only a limited power of volition over his disability removes him from the class of malingerers, so the aspect of a man neither sick nor well presents a military problem of an unusual sort. As many of these patients have been good soldiers, judgment as to their potential ability for further military life must be suspended. Where to place him and what to do with him are questions that present themselves immediately. A soldier physically fit, mentally not affected, in every outward aspect a good fighting type, not a coward, often wanting to get back to the line, but held in the grip of a mechanism which negatives his soldierly impulses, presents a problem that has mystified again and again an officer who has at heart the best interests of the men under his command. Where the number of such cases increases to such an extent as to threaten seriously man power, then more than ever do the war neuroses assume the dignity of military importance. Therefore, no statement of the problem of the war neuroses can be made without considering from the very beginning its military significance. Many of the errors made in attempting to solve the problems of the war neuroses among soldiers might have been avoided if at all times the military point of view had been kept in mind. This point of view might be expressed as the effort toward returning such a patient to his former status as a soldier, with the assumption that this is a perfectly possible thing to accomplish."

The second aspect is the clinical; this has to do with the symptoms or appearances presented by the neuroses—their classification into types and the devising of adequate methods of handling them.

The third is concerned with the mechanism of the neuroses, the obscure processes which underlie the symptoms and produce them, and which must be understood before treatment can be intelligently administered.

There are other aspects of the problem which have forced themselves into it, as it were, often complicating it most unfortunately. For example, there is the question of responsibility on the part of the patient—whether he is not morally weak and lacking in courage. The difficulty with such questions is that they do no good to the patient and interfere with the consideration of his case as a medical problem. "Strangely enough, many physicians in contact with these cases spent more time and energy in trying to decide whether the soldier, a victim of war

neurosis, was worth bothering with at all than in attempting to appreciate what it was that had happened to him. A possible explanation of this curious attitude might perhaps be found by subjecting those physicians themselves who held such curious unmedical views to processes of analysis used in studying the war-neurosis soldier. It was, in a sense, the evidence of an unconscious overactivated fear that they themselves, under proper conditions, might very well develop all the symptoms against which they showed so unsympathetic and uninformed an attitude. The proof of this statement may be found in the fact that men who have been through the actual experiences of front-line work learn to view the victims of war neuroses with a new understanding and insight. It is this tendency of defense by the exaggeration of a normal repulsion to evident weakness in another that establishes what seems to be one of the most fundamental facts in the war neuroses themselves—that is, a defensive purpose as part of the great system of physiologic conservation. There is found in presumably normal men, in this instance physicians, evidence of a mechanism of this kind, focusing on an anticipated set of experiences. The identical mechanism must necessarily be put into action when the experiences are no longer merely anticipated, but real.

"The conception of the war neuroses as a defensive mechanism or as a part of a system of physiologic conservation may be approached with less difficulty if it is made clear just what is implied by those terms. It is necessary also to appreciate the fact that the defense meant here is not conscious, but automatic and probably altogether outside of volition. There exist in all living organisms sets of factors which work toward the saving of those organisms from destruction. There exists likewise in each important function of that organism a mechanism for preventing function from becoming excessive and preventing injury to it as a whole or to its respective elements. Living would be impossible if this did not exist. The protection may be purely automatic and adjustable to mechanical factors, as for instance the hypertrophy of the heart; it may be chemical as in the immunity defense, or it may be various combinations and mixtures in which polyglandular activities come into play; it may be physiologic in respect to functional adjustments and psychical when deeper and more intricate activities of consciousness are at work. The latter may be termed physiologic, but for convenience it is better to consider it a definite psychogenic mechanism.

"This principle of organic defense appears to be a very fundamental thing, touching on the very innermost principles of living things. Naturally this principle has long been recognized and, by whatever term it has been designated, it has been an admitted fact to be considered always in the attempts to understand the phenomena of life. When the mechanism of defense, whatever its nature is, becomes inactive or less efficient, the living organism may be said to approach destruction, or if it fails

completely the organism dies. It is possible, perhaps, to divide the defense mechanism into two classes, one acting to prevent the mechanical using up of living tissue—the wear and tear of the machinery of life, as it were—the other to resist and modify the exogenous factors of a destructive kind to which every living thing is ceaselessly exposed. It is obvious that even if no sharp line of demarkation can be said to separate these two, yet the adjustability of the defense shows, in either instance, a difference in the quality of promptness and speed with which it can be put into action. The mechanically incited defensive organization is apt to be slow and cumbersome, taking place gradually according to the progress which the changed conditions of the mechanism itself necessitates, while the other must be capable of meeting quickly and decisively the immediacy of an oncoming event. Therefore, the latter type of defense must possess a certain power of selectability or adaptability because events or experiences are in their very nature dissimilar and varied. This seems to be true of the neuroses in general, and of the war neuroses in particular. If they are studied from such point of view as this, they show the characteristics of an exquisitely adjustable and often complicated piece of psychical machinery, adequately and, in a sense, personally fulfilling the purpose of protecting the individual against reëxperiencing a series of destructive events to which he has been recently exposed. The analogy between the organically inspired defense mechanism and those physiologically activated or sensitized, as some one has described them, probably goes no further than this, and the comparison has served its purpose if the fact has been made clear that the neuroses, defensively considered, are a part of a mechanism so fundamental for the preservation of life, as a physical phenomenon, that their existence cannot well be doubted. There is nothing new in this conception. Freud long ago, and others before him, had seen in the neuroses something more than a collection of symptoms simulating organic diseases. Many students of the neuroses have been impressed with the apparently needless overemphasis of symptoms in face of slight degrees of possible determining factors, and they must have seen in this, or dimly felt at any rate, that some other incentive was at work than merely processes of reaction on the part of the organism. It was in this zone of overresponse that the explanation was to be found."

This defense function of the neuroses is what fundamentally distinguishes them from the psychoses. During the early part of the war, French and British physicians were inclined to regard them as mental diseases, and the question whether they are or are not psychoses is one that inevitably arises in the mind of any one who has to do with large numbers of soldiers suffering from them. "Clinically, they are often similar to well-recognized and conventional types of psychoses. Unlike them, however, they show a surprising quality of getting rapidly and unexpectedly well." What, then, is the essential difference between the two?

"As a preliminary point the psychoses which are here touched on are the so-called inorganic types. None of those due to organic changes, or defects in the brain, or to the results of toxic or chemical processes, are considered. This is not an arbitrary distinction, but one made necessary by the assumption which has been so often emphasized that the neuroses are defensive mechanisms, demanding always as their first requisites a consciousness that can act in a normal manner.

"The difference, then, between the psychoses so limited and the neuroses lies largely in the notion that in the psychoses there is a want of a primary and logical purpose. A psychosis in the long run always acts to the disadvantage of the individual, both in relation to his immediate environment and to society. Its origin, therefore, must lie in processes of consciousness which are permanently abnormal, destructive, and constantly departing from a normally acting intelligence. Sooner or later a psychosis brings the individual in conflict with himself, his class, and society.

"The neuroses, on the other hand, never do this, nor can they do it. For as their origin and purpose are fundamentally protective, a conflict leads to the enfeeblement and eventual disappearance of the individual out of his environment. The neuroses are, therefore, protective mechanisms which tend to guard the individual from the immediate event for which he lacks proper personal adaption. The psychoses, on the other hand, serve no protective purpose whether immediate or remote, but on the contrary tend logically to the destruction of the individual in the conflict of events. They are permanent deviations, progressive in type, which arise without set purpose, and are the consequences of abnormal processes in consciousness. They tend to the elimination, not the saving, of the individual. In the struggle with society it is generally the individual who succumbs, either as a living organism or as a member of a social order. The neuroses, on the other hand, are the products of an intelligence awake to the needs of the individual and are structures of compromise between him and society. They tend to shield him and so do harm to society. They arise in consciousness from fully realizable premises, but tend to become automatic and without the individual's awareness, so that he reacts to them instead of the things that he is cognizant of in his own make-up.

"It is to be noticed that in this definition of the neuroses there is no attempt to fix on an etiology. The causative factor of events is touched on, but it is given no specific meaning. In the war neuroses, on the other hand, there is the qualifiying factor of war, and this definition, to have any value for the present purpose, must hook up with the ever-present set of circumstances associated with military activity in war time. This brings with it an important element scarcely hitherto touched on in this paper, and that is the instinct of self-preservation and its activating source—the emotion of fear.

"No attempt will be made here to define instinct. Two of the instincts may be called primary, primitive, or fundamental. These two are the instincts of self-preservation and propagation. They represent certain necessary qualities of life without which life would be impossible. That is, it could not continue. To be continuous it is essential that the individual should live at least long enough to propagate, in this way preserving the quality of continuity. Neither of these two qualities is possible without some mechanism tending in the long run to preserve life as existent, and to prolong it beyond its individual expression. These two instincts might be termed essential because they are necessary parts of the phenomenon of living.

"In the other instincts, and their number is as great or as little as is preferred, it is found that they do not represent these innate and essential qualities, but do represent certain tendencies or impulses which depend rather on racial or species experiences. These are the things that have in the long run acquired a certain positive value in the struggle both to prolong the life of the individual and to render as easy as possible the passing on of life beyond the individual. Such tendencies are probably acquired and inheritable. By repetition from one series of individuals to another they become dominant. The nervous mechanism by which they are set in action becomes by each successive wave of individuals more adapted and prepared for the reception of the sensory excitant, the emotional background, and the motor outlet. In some such way they tend to develop into complicated reflexes, each one of them conditioned by a particular set of circumstances.

"In the war there is the essential instinct of self-preservation. This is the instinct primarily involved. Many of the others play their part, but are secondary and unessential. In the war neuroses the motive is furnished by the presence—in a very active and, to the individual, unusual way—of the instinct of self-preservation. The war neuroses may be looked at, then, as an elaboration of this instinct carried out, as primary instincts always are, without the individual's will or knowledge. They are defensive, automatic adaptations on this basis because the individual has no longer the power of adapting himself to immediate condition and he surrenders himself to a more powerful defense than he himself can possibly, consciously, construct."

A question that has been much discussed in connection with the war neuroses is that of what has been called neuropathic inheritance tendency.

"The reasoning ran something like this. No soldier who is not of a neuropathic type can develop war neurosis. The fact that he shows symptoms of this condition is an admitted proof that he belongs to this class. Thus, having arrived at this conclusion, all that remained was to find evidence supporting this contention from the patient's past history or the stock from which he came. In a very high percentage of cases

sufficient data of this kind could be found. This was taken as proof of the contention."

But a study of the personal histories of large numbers of soldiers, both those who were suffering from war neuroses and those who were not, seemed to show that neuropathic inheritance tendencies played a very small part in the production of the neuroses.

"Fear and fear reactions certainly cannot be set down as neuropathic traits, and as they are the most important energizing factors in the etiologic sequences of war neuroses, it follows that any soldier, neuropathic or not, may be viewed as a potential case of war neurosis. This, after all, seems to be the most illuminating point of view and by far the most useful, and as such it fits in with the conception advanced in this paper. As a possible predetermining influence in the series of incidents leading to the development of war neuroses in a soldier, neuropathic inheritance has some importance, but an importance completely overshadowed by the more active set of traumatically converging incidents which will now be described.

"In order that the mechanism of automatic defense may be set to work, the average soldier must undergo a series of events which tend to weaken what may be roughly and rather inexactly termed his ordinary self-control. By this is meant that he must be put temporarily in a condition where his normal mechanism of inhibition is seriously weakened. By inhibition in this sense is meant the totality of his power to control the natural exhibition of the phenomena of fear, terror, nervousness, horror, etc. To this must be added the positive factor which strengthens the inhibitory impulses—that military quality which keeps alive and ever present in consciousness the recently acquired traditions and customs of a soldier. This is an element of morale. The mental process by which this is accomplished is suppression or repression. Inhibition is merely a larger and more physiologic way of expressing it.

"The important set of circumstances which tend to weaken this faculty are: (1) exhaustion; (2) fatigue—the more chronic phase of exhaustion; and then in succession sleeplessness, lack of food or water, worry, responsibility and incidents of a particular, horrifying or unaccustomed kind, loneliness, strangeness, ill-treatment, etc. The list of these incidents might be endlessly multiplied, but enough has been set down to indicate their character. The importance of incidents like those that have been mentioned and others of a similar kind lies in the fact that they tend, each of them or in combination, to weaken the individual and to prepare the way for the reception of the final traumatic incident. They create in the soldier, so to speak, a favoring terrain; they further tend to develop in him a soil of receptivity, in which or on which the neuroses, given the proper setting, can easily develop, become fixed and chronic. In opposition to these, the soldier, according to his peculiar personal make-up, struggles either forcibly or feebly

according to the measure to which he has surrendered himself to his career as a soldier. Back of all this lies no doubt many an emotionally-tinged impulse, leading straight back to his former nonmilitary existence. Among these may be mentioned the mass effects of discipline, or morale, the grip of idealism which led him to offer himself as a fighter, his experience with the German as an antagonist, the memory of slaughtered friends or comrades, his love for his officers, the honor and reputation of his regiment, and things of that sort; all of them or some of them are present in the make-up of every soldier. They form the counterflow against the on-rush of factors which center about the condition called fatigue or exhaustion. It is to be noted that in whatever stage of fatigue the soldier now happens to be, he is still in possession of consciousness and a knowledge of himself. In no way has he departed from the condition of a consciously controlled human being. No matter how feebly the inhibitory impulse is asserting itself, it is still to some degree active, and to that extent the soldier is aware of himself as a soldier, perfectly responsible and responsive to the demands of his position. It may be argued that, in the extreme stages of fatigue, the condition of automatism may be reached, but even if this were so, its approach is too gradual to permit the neurosis structure, instinctively fortified by the necessity of self-preservation, to take complete hold of him. At this stage there comes into play a very important and significant psychologic element in fatigue. This is a very unusual and possibly suddenly developed state of suggestibility. This extraordinary state of receptivity, not only to outside things, but also to ideas, memories, and emotions of endogenous origin, forms, perhaps, the most favoring circumstance for the development of the neurosis which at this moment is awaiting an opportunity to enmesh the individual in its defensive system.

"From this point on, two sets of things may happen. Both of them have a precipitating effect and both tend to act in a positive and dynamic fashion equally effective in the production of the first and necessary phase of a war neurosis. One set of incidents has to do, in a certain proportion of cases, with the purely mechanical results of a shell explosion in the immediate neighborhood of the soldier, by which he is shocked to a greater or less degree, so that there is momentary loss of consciousness, or it may extend over some hours, as the case may be. As a rule, he either falls or is thrown to the ground, or wanders about in a confused way, and immediately enters into a state in which conscious inhibition is for the time being totally in abeyance. The other set of incidents has to do, not with a mechanically working factor, but with the appearance on the scene of some sudden, unusual, or terrifying experience which, emotionally overloaded, tends to produce exactly the same condition."

Frequently, though not always, this experience is a shell explosion and the resulting concussion.

"Whatever the immediate factor may be, a period of unconsciousness,

confusion or a dazed condition appears to be one of the most significant and almost necessary preliminary states favoring the development of a neurosis. Such a condition offers to the protective mechanism the opportunity to work, unaffected by the ordinary control of the touch with reality, which is implied when consciousness remains undisturbed. That a neurosis can develop without an intermediary state is of course true, but in these instances the mechanism at work is of a much slower and more complicated kind, leading to approximately the identical condition through endogenous processes largely activated by emotional hyperreactions, breaking through consciously acting repression.

"Looking at the thing as a process, and nothing else, there is evidently a state reached by the soldier going into a neurosis when, for the time being, his conscious control is weakened or lost, and at that period the instinctive reactions take possession of him, and uncontrolled by anything that he can at that moment interpose to counteract them, open the way for the self-preservation instinct to obtain its fullest influence. At any rate, he remains under its control until one of two things happens. One leads back directly to the restoration of himself in his soldier capacity, in which instance no neurosis develops; the other, further and further away from his normal soldier self into something totally unlike and alien to the thing that he was, and then he begins to show one of the many types of the war neurosis.

"In the course of this process another important element in the mechanism comes into play, especially during the period of transportation to a hospital and in the early days of the soldier's stay there. The process by which the initial symptoms become either temporarily fixed or tend to further elaboration has been described by various terms. None of them are, however, very satisfying. What happens is that there is given an opportunity for more complete concentration and introspection, so that the individual, removed from contact with his accustomed environment and away from the external influences of camp, line and military discipline, easily surrenders himself to his neurosis, which automatically tends to further elaboration and intensification of symptoms. If this is not counteracted by skillfully planned medical intervention, intensive, and above all promptly put into effect, the war-neurosis subject falls under the complete sway of his neurosis and the picture becomes completely that of a well-developed and chronic type. That there is more at work in this stage than pure automatism and unconscious impulses must be admitted. That there gradually develops a fairly active desire not to get well, but to remain in the apparently safe grip of the neurosis instead of facing a return to conditions which led to its production seems also evident. There is also here seen the beginnings of another process—that is, a struggle between the innate desire to return as a soldier and the automatic persistence of the preservative tendency previously alluded to. Cases left untreated, neg-

lected, or contemptuously handled rapidly develop into this state, and as a result form the most difficult subjects for subsequent treatment.

"There is a group of cases to which much that has been described above does not apply. It is mentioned here because it occurs in a condition very largely met with in the officer class and which may or may not have as an etiologic factor the acute traumatic incidents seen so frequently in the soldier types. The anxiety neurosis has a mechanism which is more complicated and in which the defensive element is obscured by the presence of an intense and persistent conflict. This conflict has its origin in the necessity, which an officer at all times is conscious of, to conceal from the men under him and from himself, too, every evidence of emotional stress he may be passing through. This he does by the use of repression. The repressed material of his experiences, notably those in which emotional loading is strongly present, activate the conflict between his desire to maintain and follow the tradition and training of an officer and the strongly entrenched but completely unacknowledged instinct to save himself. The essential difference between his reaction to the sequence of traumatizing events, just described, and that existing in the case of the soldier, lies chiefly in the fact that there is an ethical element at work which intensifies the conflict and causes him, in many instances, a great degree of mental distress, suffering and self-accusation. This produces the state of anxiousness which is often the only and sometimes the chief evidence, externally at least, of his neurosis. . . .

"The anxiety type of neurosis presents a much more highly developed, pure psychologic defense than the other forms. Its relation to physical factors is often much more difficult to demonstrate. In fact, it is often found developing after a rather long sequence of psychically acting traumas showing markedly insidious progress and evidently originating from insignificant and not easily demonstrable beginnings. Its defensive character is chiefly in the fact that it renders an officer incapable of positive action, reducing him to a state of neutrality. In this condition he becomes, one might almost say, the prisoner of his conflict, and remains inert, without energy, without initiative, controlled almost wholly by the emotional stress engendered by the conflict going on within him. He is frequently unaware that such a conflict is present, the repressing mechanism working automatically to keep out of his waking consciousness all evidence of a thing of this sort. What he is aware of, and that very acutely, is his own mental distress and the physical expression of the emotional strain he is under. These external signs of fear, worry, etc., are dissociated in his own consciousness from the sources to which they owe their origin, and he is thus as much a puzzle and mystery to himself as he is often to the neurologist under whose care he may happen to be.

"Several bits of qualification must be added to much of what has

been written in this attempt to state the clinical problem of the neuroses from the point of view of its underlying mechanisms. It is necessary to appreciate the fact that in trying to trace the sequence of happenings which a soldier passes through on his way to a neurosis, an average of such experiences was recorded, something that might be accepted as a plan of a physiologic experiment if the soldier could be made into a laboratory problem. There is no thought of making this entirely applicable to every case of war neuroses, or, in fact, is it certain that any one ever passes through just the things that were described. Of all things in the world the war neurosis lends itself least to dogmatic statements, but what has been set down appears to be a reasonable explanation based on an analysis of many hundreds of cases."

The following classification of the war neuroses was adopted at Base Hospital 117:

1. Neurasthenia
2. Psychasthenia
3. Hypochondriasis
4. Hysteria
5. Anxiety neurosis
6. Anticipation neurosis
7. Effort syndrome
8. Exhaustion
9. Timorousness or state of anxiety
10. Concussion:
    (*a*) Syndrome
    (*b*) Neurosis
11. Gas:
    (*a*) Syndrome
    (*b*) Neurosis
12. Malingering

Some of these, such as malingering, are not neuroses at all, and others are questionable, but they are included in the classification for purposes of diagnosis because they represent conditions which a neurological hospital in the war zone is often called upon to handle. Dr. Schwab analyses the more important of these types in some detail. The symptoms of the first three—neurasthenia, psychasthenia, and hypochrondriasis—correspond closely to those of the civilian neuroses thus designated. In the first, fatigue is the predominating symptom; in the second, doubt, the inability to make a decision through fear of the consequences; and in the third, preoccupation with ideas of disease. The defense character of these three types is evident. All three are consciously originating neuroses. "This does not at all imply that they are either willfully or designedly produced, but that they play themselves out in the upper zones of consciousness and awareness."

Hysteria and the anxiety neuroses, on the other hand, "both represent unconsciously produced neuroses, and both are types of a dissociation process." In hysteria, the mechanism of dissociation blocks from consciousness and conscious control some functional activity, either in its motor, sensory, or psychical capacity.

"The dissociation process is most frequently set in activity by a somewhat sudden emotional or physical shock and, in the latter instance, the precipitating factor is most often the effect of a shell explosion or some type of trauma associated with some degree of violence.

The type of reaction in hysteria both in respect to localization and function bears a definite relation to the local effect of the trauma. Blindness is often the result of the acute blinding sensation of an explosion, deafness due to the momentary loss of hearing. For the same reason, sensory disturbances are due to numbing of areas of skin following disturbance of atmospheric pressure in the zone of an exploding shell, etc. The emotional precipitating factors have the same curious localizing tendency, with the exception that here suggestion or imitation seems to show a more active influence. It is necessary to point out that in hysteria, particularly the acutely established types, is shown less clearly the characteristic protective defense than in some other types of neuroses, and it must be admitted that in some instances it is only after the primary disturbance has manifested itself, whatever its nature may be, that the defensive mechanism is set to work and then chiefly in the direction of fixing it and making it more permanent.

"A sudden shock having a positive degree of physical incidence may throw out of activity a certain function or a part of it, certainly too rapidly for any kind of psychical mechanism to be set going. In such instances the instinctive action of self-preservation arises later, automatically making that loss of function fixed, thus establishing it as a neurosis of the war type."

Hysteria was the most easily cured of all the war neuroses and the anxiety neuroses were the most difficult.

"It is in the anxiety neuroses that the most complete example of psychical dissociation is met with—that is, a dissociation unaccompanied by anatomically expressed loss of function. It has to do with a more general process and reaches down more deeply into personality than the more superficially located mechanism seen in hysteria. Something of the etiology and the primary reaction have already been touched on. There remains to describe progress and final clinical results. The subject of an anxiety neurosis must be thought of as an individual in whom the repression faculty is well developed. This may come about either as a personal characteristic, or it may be due to the position of authority due to his military position. Naturally the officer falls most easily into this class, and it is in the officer class that the majority of instances of anxiety neuroses are found. . . .

"In almost all instances, an officer very early in his career, very likely even in the training camp, feels the necessity of repressing his dislike or objections to discipline, obedience, authority, and many of the other essential phases of military life. His repressive mechanism not only has to do with the ideas themselves, but also with the external evidence of his attitude toward them; that is, his conduct must depart in no way from the correct military form. For these, and indeed for most of the experiences associated with actual combat duty, the repressive func-

tion is amply sufficient to keep the officer from ever approaching the territory of the neuroses.

"The repression faculty has a well known tendency to become automatic and to act entirely without the intention of the individual. As the officer advances in his training, and as military life grips him more and more intensely, and as military discipline forms him into a silent part of the big army machine, he is less and less in need of any active manifestation on his part of this faculty of repression which was so much a part of the mental discipline of the earlier days of his training. It must not be forgotten that in the A. E. F. the professional class of officers was necessarily a small one and that most of the nonprofessional officers were taken out of civilian pursuits of various kinds in which no trace of military atmosphere and certainly none of active combatant duty were to be found. Therefore, there was no important set of military or officer traditions to which the future officer had long ago accustomed himself. In England, of course, there was, and there is no doubt that this had a definite influence on the number of anxiety neuroses among them.

"Therefore, it should be appreciated that in our army the traditions of conduct in general and particularly those associated with active military life had been very recently acquired, so recently that they were only superficially grafted on the officer's personality. There was need, then, to exercise, whether consciously or not, that form of inhibition called repression in order to maintain such traditions under circumstances of difficulty. This was especially necessary when the officer met front-line conditions for the first time, when he had not only himself to keep in hand, but also the added responsibility of men under him for whose fortunes in the stress of trench or open warfare he held himself in a measure responsible. In addition to this he realized that the technical side of his profession, a most difficult and intricate thing, was also but recently and often most laboriously acquired and had now to withstand the actual and often bitter test of real combatant conditions. Notwithstanding these heavy burdens, very few officers, it must be acknowledged, did, even under the adverse conditions associated with front-line conditions, develop a neurosis. Those who did had to face peculiar sets of circumstances which tended to break down the inhibitory processes which held them together in their capacity as leaders of men. Under the strain of fatigue, exhaustion, worry and some of the many incidents that have been before alluded to and as a result of shell explosion with a concussion sequence, the faculty of conscious inhibition was temporarily lost and the officer acted for the time being as a primitive, instinctive piece of human machinery and during the period of semi-automatism, confusion, or haze, the beginning of the neurosis of the anxiety type was laid. If some of these things did not

happen in an acute manner, then a series of smaller and less important incidents brought the officer in exactly the same condition.

"From this time on, the conflict began to assert itself coupled with the dormant repressive tendencies, which again came into activity as the reality of the situation became more and more apparent. It is this antagonistic relation of conflict to repression that tends toward the separation of emotion from experience. This supplies the mechanism of dissociation alluded to before. There results then the clinical picture of a state of intense anxiety with the external evidences in the way of facial expression, depression, apathy, anxiety, loss of sleep, dreams and even the objective appearance of fear, tremor, rapid pulse, vasomotor reactions, in the face of the complete unawareness and lack of understanding on the part of the patient of what really is at the basis of his discomfort.

"The battle experiences repressed, and in a sense partially forgotten, tend to express themselves by freeing their emotional content or by spinning themselves out in dramatic and terrifying dreams. There is present, then, the evidence of fear and terror without being related to either actual experiences themselves or even to the actual memories of such experiences. In this state there develops a series of conflicts which must be regarded as being hardly conscious in some instances and wholly so in others. These seem to have been the more usual: (1) The conflict between the desire to go back to the front and the negative desire or wish for self-preservation. (2) The conflict arising between tradition and training of an officer and the desire to escape front-line conditions. (3) The conflict between the desire to avoid the dangers and discomforts of the front, and previous ideas of duty, valor, etc., and family, social, personal and class standards. (4) Conflict between the desire to escape and the feeling of inadequacy, in a military sense, of the responsibility of an officer in command of men. (5) Conflict between the impulse to go forward and the wish, expressed or not, to go back to former conditions in the United States. (6) Conflicts which have reference to events or similar types of conflict in pre-war experience.

"Naturally there are many other kinds of conflicts, but these were so common in the cases seen in Base Hospital 117 that some of them were predicted in certain individuals and were actually found to be present."

In the treatment of the war neuroses, certain general principles were followed at Base 117.

"The first principle of the hospital was to cure the soldier and send him forward. If this were not possible, he was to be fitted for military service in the S. O. S., with the hope that he would soon reach the front-line status. The very fewest cases were to be sent to the United States; therefore, D classification was permitted only in the

absolutely hopeless cases, and these chiefly on account of some undercurrent organic malady or previously undiscovered organic lesion of the nervous system. . . .

"The second general therapeutic principle was that a patient's stay at the hospital was to be as short as possible—the average in the whole hospital was slightly above three weeks. This included the officer material which required long treatment, and also included delays in getting patients out, due to transportation difficulties and all other sources of block incident to a hospital operating at the time of active fighting.

"The third general therapeutic principle was that all attempts made to cure a patient should be instituted as promptly as possible—within forty-eight hours if it could be arranged. Associated with this was the idea, also, that when the attempt was made it should be followed through to a finish at one sitting. This, of course, refers only to the hysterical symptoms.

"The fourth principle was that the war neuroses were caused by a mechanism not under the patient's control in its initial phases, but subsequent to that, in two to four weeks, there might be a contributing factor in the retention of symptoms through the desire or wish of the patient to remain protected by his neurosis. At least this possibility was kept in mind, so that if a cure was not effected within that time, the question of the patient's coöperation was brought up.

"The fifth principle was that work of some kind was one of the most important aids in effecting symptomatic cures, so that always more than 80 per cent of the patients were engaged in work of some sort. This work was of a varied sort, work in the fields in season, road making, wood chopping and work in a special shop—a therapeutic workshop carried on by civilian aids. The only novel feature in this was that it was carried on in a hospital to meet war conditions within a comparatively short distance from the front areas."

In cases of hysteria and of anxiety neuroses, the treatment included explanations to the patient of the causes of his condition, so that he might understand it and coöperate with the hospital authorities in overcoming it. Special dependence was placed upon this method of treatment in the anxiety neuroses, which offered little opportunity for direct therapeutic attack.

"The therapeutic aim in the anxiety neuroses had formerly been to encourage the patient to forget his experiences and to aid by his own effort the automatic repressive tendency already existing. The new point of view was to attempt to train the patient to face, and to face daily as a matter of course, the experiences he had been through, no matter how uncomfortable or terrifying they happen to have been. This, by the way, was not original in this hospital. Charles Myers of Cambridge had carried out this process by means of hypnosis very

early in his experience with cases of shell shock, and later Rivers had advised it as a perfectly feasible thing to work out without the use of hypnosis at all. It was in a sense a modified psychoanalytic procedure adapted to a war-born condition, divorced from a good deal of the technical complications of the method used in peace times.

"A patient was encouraged to talk about his experiences, to go over the emotional state which accompanied them, and to examine himself as critically as he could in reference to them. It is one thing to face a past event and to measure oneself in the light of that event; it is quite a different thing to try to forget an event and thus allow the criticism, so to say, to go on unconsciously and the resulting emotion to remain as the only conscious evidence of the conflict going on sublimated and beyond reach. The former state of mind was encouraged in the patient, the latter was to be avoided. . . .

"Therapeutic use was made of many other agencies not usually mentioned in describing methods of treatment. All of them had to do with strengthening the patient's morale, and forcing on his attention at all times the necessity of getting out of the hospital and back to duty.

"The hospital chaplain, Lieut. George Taylor, approached this through wisely and cleverly designed sermons touching on the spiritual phases of courage, loyalty, devotion and patriotism. The sermons and religious exercises were planned in part toward this end, as were the weekly talks by members of the staff and sometimes by visitors to the hospital. In other ways the military atmosphere was kept alive by every means possible. The decorations in the recreation huts were all planned to keep the military atmosphere in the minds of the soldiers through stirring posters and scenes of actual war conditions. The walls were covered by sketches, drawn for the most part by patients, of men going over the top, artillery going into action, aeroplane fights, etc.

"Sympathy in the ordinary meaning of the term had little place in this hospital; intelligent insight and appreciation of the mechanism of the war neuroses in a measure took its place. The military necessity was accentuated and kept constantly in mind, but notwithstanding a certain grimness in the hospital's attitude to its patients, not the slightest suggestion of harshness or severity was ever permitted. The war neuroses were regarded as temporary conditions into which a soldier might fall and thus become a subject for medical treatment. The treatment was bound to fail unless the efforts made to help him met with the coöperation of the patient and a desire on his part to get well. The hospital was planned and equipped for the purpose of returning him to duty and, given his support, did in most cases succeed. If expressing his recent experiences by talking, writing, or even, as was done in some cases, by the most lurid drawings was an aid to this end, such efforts were encouraged by whoever might happen to be at the time helping

on his case, be it *padre*, civilian aid, nurse, or some other specially qualified member of the hospital personnel."

About 65 per cent of the men treated at Base Hospital 117 were returned to active duty; about 30 per cent were sent to S. O. S. duty; the remainder were judged to be totally unfit for military duty of any kind.

"In the forward neurological stations the percentage of returned cases was much larger, and in the *triages* larger still. This means, of course, that the prompt treatment of incipient cases at the hands of experienced men can prevent in many instances the full development of the neuroses in a fixed form."

In closing, Dr. Schwab emphasizes the importance of bringing to bear upon the problem of civilian neuroses the knowledge, insight, and experience gained in the treating of the war neuroses.

"If this is not done, the war neuroses are no more than an evanescent item in the casualty lists. The war neuroses are specific war-born conditions, and with the ending of the war they disappear from clinical experience. Their place is taken by the civilian neuroses, which are different things.

"What remains are the mechanisms and therapeutic methods. These are the unchanging elements and understanding them is the permanent gain. All that is necessary is to replace the conflict of battle by the conflicts which result from social and economic stresses, to substitute less fundamental instincts for that of self-preservation, and to cultivate in treatment the same therapeutic eagerness, definiteness and incisiveness which were found effective there. If this is done, the 'return-to-duty' cases in the civilian neuroses will reach and pass beyond that which was possible among the soldiers who were treated in the various divisions of the neuropsychiatric organization of the A. E. F."

BOOK REVIEWS

EDUCATION FOR CHARACTER. By Frank Chapman Sharp. Indianapolis: Bobbs-Merrill Company, 1917. 453 pp.

This book is a clear, concise, and practical outline of the simple, fundamental principles of everyday morality, written especially for the schools, with the common sense and insight of a practical teacher. That it merits a review in MENTAL HYGIENE is clear when we reflect that the fields of mental hygiene and of practical morals overlap, and that precisely these simple, fundamental principles of morality are, in many cases, likewise fundamental principles of mental hygiene.

If one presents the commonplace rules for mental hygiene for the normal, and the simple principles of social education essential for the development of healthful habits of mental activity, the comment is likely to be made that it is morals rather than hygiene that one is discussing; and if, on the other hand, an ethical writer presents, as Professor Sharp has done, the commonplace rules of practical morality and gives practical suggestions for moral education, the hygienist at once recognizes that in large part precisely these rules and principles are vitally significant for mental health.

The sooner we recognize this common ground of morals and mental hygiene, the better. For centuries the chief literature of mental hygiene was that written by the moralists and religious writers. It is true that this contained a large amount of superstition and error; but gradually a universally recognized code of morals has been developed, and this has been also a great contribution to mental hygiene. And to-day the contributions of scientific mental hygiene are of the utmost importance for moral and religious teachers. In a word, hygiene can learn much from the amateur mental hygiene of the moralists—that nucleus of common-sense, practical wisdom gradually developed by the experience of the race; and, on the other hand, nothing is more vitalizing and practically helpful for the moralist than the contributions of the scientific mental hygiene of to-day.

Professor Sharp discusses with practical illustrations and suggestions such topics as the place of moral education in the school, the influence of personality, the tone and discipline of the school, the extracurricular activities of the school, the work of the teacher, and moral training in its various aspects, together with the practical methods of moral instruction and training that may be utilized in the home and the school.

The chapter on moral education in the home gives perhaps the best illustration of the common field of mental hygiene and of morals just mentioned. If the simple principles here discussed and the practical

suggestions given were followed in home education, it is not too much to say that a large number of cases of nervous and mental defect would be prevented. Precisely such principles and methods are those adopted as the most helpful in the reëducation of nervous and mental patients in the hospitals and sanitariums. That the application of these in home and school education would be far better for prevention than for cure is obvious.

Mental hygiene emphasizes the fact that one of the most important conditions of mental health is the development of right attitudes toward others and toward life. These, of course, are formed largely in the home. A single concrete illustration of the overlapping of hygiene and morals is furnished here by Professor Sharp's discussion of the trite, but vital, subject of example.

"When a child sees his father treat his mother like a boor, how is he likely to treat his sisters? When the conversation at the dinner table consists chiefly of malicious gossip, innuendos, sarcastic flings at neighbors or relatives, a cynical interpretation of other people's motives, assumptions that what the parent speaking does must be right and that any one who denies it must be either a fool or a knave—with what views of life and of himself is he likely to grow up?" Such attitudes are dangerous from the point of view of hygiene as well as of morals.

Again, as regards the subject of punishment, Professor Dewey's article in the *Popular Science Monthly* on *The Chaos in Moral Training* is cited; and Professor Sharp adds: "What does most harm, perhaps, because it rankles longest, is injustice in punishment. Professor Dewey once made a collection of the youthful experiences of his students in this matter. One boy was whipped for taking his father's tobacco and using it. No questions were asked and no explanations given. The boy thought his father whipped him because he wanted the tobacco himself. A girl saved pennies which her father had given her to take to Sunday school and bought a valentine with them which she gave him to surprise him. The father threw this into the fire first and then punished her, taking it for granted that she knew she was doing wrong. Not even after that, however, did she feel it was wrong, but rather felt indignant and humiliated that her father had treated her gift in such a way. . . . Few things that the parent can do will have a worse effect upon a child than inflicting undeserved punishment. The effect of such treatment upon one of Professor Dewey's students was that he longed to become old enough to retaliate. One way to avoid such tragedies is not to permit one's self to punish in wrath."

Such practical illustrations and the application of moral principles to school work commend this book to teachers, and indirectly its contribution to mental hygiene is important.

WILLIAM H. BURNHAM.

DEFICIENCY AND DELINQUENCY. By James Burt Miner. Baltimore: Warrick and York, 1919. 355 pp.

The author, when confronted a few years ago with the mental measurement of delinquents in the Hennepin County Juvenile Court at Minneapolis, found himself very much in need of a statable border line of intelligence defect for adults. With the full recognition that intellectual defect constitutes only one symptom of feeblemindedness, it appeared to him perfectly logical that there is an upper limit of intelligence or intellectual capacity which may in and for itself be considered a sufficient reason for antisocial behavior.

With this point of view in mind, he selected objectively a group of fifteen-year-old children in Minneapolis, where the school registration is accurate and effective. In seven typical districts of the city there were 653 fifteen-year-old children, 322 of whom were boys. Among these were 196 who had not graduated from the eighth grade. These were measured by the Binet 1908 scale, with the exception of one child, who was in a hospital on account of illness. A thorough search was made for fifteen-year-olds from these districts in institutions. None was found.

As a result of this thorough study of the lower-grade fifteen-year-olds in these typical districts of the city of Minneapolis, the author finds substantial evidence for the view that the state may be justified in isolating indefinitely the lowest 0.5 per cent of the population mentally on the basis of their decided lack of intellectual capacity. The next highest 1 per cent, comprised of those between 0.5 per cent and 1.5 per cent, of fifteen-year-old intelligence, being in life age fifteen years or older, he finds himself justified in calling "the social-assistance group." Many of these will prove by their delinquencies that they are feebleminded, and all of them may be expected to require social assistance indefinitely.

The Minneapolis data from these normal fifteen-year-olds, and the results presented from the Glen Lake Farm School, near Minneapolis, constitute the original contributions of this monograph. The main contention, however, is for a percentage definition of deficiency as against an intelligence quotient, a coefficient of intelligence, or amount of deviation from the normal, as a means of judging feeblemindedness. Notwithstanding the "natural antipathy of many people to anything which tends to limit the charming vagueness of their mental outlook," the author proceeds to make a very thoroughgoing review of the effect of applied psychology in the field of delinquency in the past decade while it has worked without definite limitations of the concept of feeblemindedness.

He shows, for instance, that the standard used by Dr. Printner in his report of one hundred juvenile-court cases, if applied to the Minneapolis group, would have classed 20 per cent of them as feebleminded, instead

of the 2 to 7 per cent thus classed under the author's more conservative border lines. He comments on Dr. Hickson's classing "728 boys who average XI.11 years as morons," while he considers ten-year mentality the probable limit for persons fifteen years or more of age. He assembles in one table the results of about forty different studies of groups of delinquents, standardizes these according to his own percentage definition, and finds the very large percentages stated for the Newark Detention Home, New Jersey, and the Allegheny County Juvenile Detention Home, Pennsylvania—percentages stated as 66 and 55 respectively—to be due to the fact that these institutions harbored unusually large numbers of recognized feebleminded delinquents, because the states concerned had not made proper provision for the same in institutions designed for mental defectives. In fact, the author traces a general tendency to overstate the percentages of mental defectives among delinquents to the very large numbers which Gifford and Goddard found in the Newark Detention Home.

In his discussion of deficiency as a cause of delinquency, presenting evidence from Goring and the Report of the British Royal Commission on the Care and Control of the Feebleminded, he states "these estimates afford a telling argument for the indefinite isolation of at least those who are in the lowest 0.5 per cent mentally on the ground of their potential criminality, independently of any question of the danger to society from the hereditary transmission of the diathesis of deficient delinquency."

A few chapters near the end are devoted to theoretical considerations, taking up the theory of measurement of mental development and quantitative definitions of the border line. Karl Pearson's suggested use of standard deviation, i.e. of $-4S$ D as a border line, is shown to be inapplicable to other school surveys than Jaederholm's at Stockholm. The percentage limit, with the author's suggested one-half of 1 per cent of the general population, is found to be much more serviceable and, until we know more of the facts involved, as scientifically accurate a means as is available for separating the intellectually deficient from any given population. We possess at present no statable units of measurement in terms of which mental retardation can be expressed. The percentage definition is reasonably accurate and will have the effect of tempering and equalizing the statements of different workers in various fields of delinquency.

THOMAS H. HAINES.

SPEECH TRAINING FOR CHILDREN; THE HYGIENE OF SPEECH. By Margaret Gray Blanton and Smiley Blanton, B.S., M.D. (University of Wisconsin). New York: Century Company, 1919. 261 pp.

This book is a definite contribution to the science of mental hygiene. More closely, it might be spoken of as a study of the hygiene of emotional expression in children with special reference to speech. While

the book is written primarily for parents and teachers, it is of especial importance to the physician, who is interested in recognizing and correcting in children the first traces of what may, if left uncorrected, give rise in later years to nervous or mental handicaps. The book abounds in concrete suggestions for the stimulation of healthy emotional and intellectual growth. It contains wise estimates of commonly practised methods of dealing with children and discusses measures for the correction of unfortunate habits in children and adolescents.

From the standpoint of the authors, the orderly development of intellectual and emotional functions is dependent upon a general capacity for muscular coördination—a development of the kinaesthetic sense—adequate to favor a free adjustment to the child's environment, and to facilitate by it at the same time a free flow of the appropriate feeling or emotion. Defects of expression in speech, the authors reiterate, delicately guage irregularities of this development. Hence, by intelligent heed to the speech of the child, the authors claim, much may be discerned of crucial importance in its inner life. Difficulties of expression by speech are therefore to be corrected, not only by attention to the vocal and enunciatory apparatus, but also, and often mainly, by attention to more fundamental functions. In this latter connection, the authors emphasize the matter of unfortunate emotional tension.

For the reader who wishes formal directions and means for carrying into effect the suggestions of the text, the authors have provided nearly sixty pages of exercises. In these, as in the text, the authors maintain an attitude of appreciation of the problems from the standpoint of the child and yet reach by precision the end sought.

The book is written in a clear style free from tedious technical details. It should go far in stimulating an interest in a function as much neglected in its purely educational bearings as in its importance in relation to mental hygiene. The authors present in summary one aspect of their interest as follows: "The child cannot dominate the world. If he could, it would not bring him happiness. . . . The earlier he is taught the simple—in the beginning—practice of looking at his needs from the point of view of society, desiring for himself only those things that would be reasonable if demanded by the whole race, and accepting those things that it were not well should be changed, the greater will be his opportunity for normal emotional life and healthy spiritual development. Normal speech is only present where these two attributes are present."

G. S. Amsden.

Handbook of Mental Examination Methods. By Shepherd Ivory Franz. Second edition, revised and enlarged. New York: The Macmillan Company, 1919. 193 pp.

The second edition of Professor Franz's handbook appears at a particularly opportune time. The renewed and increased interest in

psychiatric problems and the distinctly important place they now occupy in medicine and public health have given rise to a demand for information on methods of approaching and elucidating these problems. There is, too, a demand for more exact and standardized methods.

Professor Franz in his book meets these needs to a very large extent. The handbook sets forth briefly and clearly each subject to be investigated and then, with equal clearness, describes the methods of observation and tests to be applied. The new chapter, XII, *Mental Tests*, is especially worthy of careful reading. It is also interesting to find that the author thinks well enough of Woodworth's *Tests of Emotional Instability* to include it in his book.

While Professor Franz writes largely from the standpoint of a psychologist, his handbook will be found invaluable by all who are interested in the examinations of mental disorders.

M. W. RAYNOR.

CONDUCT AND ITS DISORDERS, BIOLOGICALLY CONSIDERED. By Charles Arthur Mercier, M.D., F.R.C.P., F.R.C.S. New York: Macmillan Company, 1911. 377 pp.

The author undertakes in this book a systematic presentation of the nature and varities of human conduct and its disorders and an outline of a science of "Praxiology" as distinct from "Psychology." In the very first page of the introduction, we come across the statement, "In treating of conduct it is desirable to eliminate, as far as possible, reference to mental states and processes."

In so far as the subject of human behavior lends itself at all to this type of treatment—i.e., to a treatment of it without reference to psychology—the author has accomplished his task well.

The book does furnish a lucid and systematic presentation of the nature of action, of the different kinds of action of which man is capable, of the ends that he seeks to compass, of the relative importance of these ends, of the harmony or conflict among them, of their subordination and superordination to one another, and of the biological reasons on which they are based.

It is difficult, however, to follow the author in his explicit intent to avoid psychological considerations in the treatment of his subject. Already, in the discussion of instinct and instinctive behavior, to which Mercier devotes two very interesting chapters, the ignoring of psychological factors would bring him into conflict with the more widely accepted theory of the nature of instinct, namely, that it is an inherited or innate psycho-physical disposition involving psychical as well as physical elements and possessing cognitive, affective, and conative aspects. As might be expected, therefore, Mercier does not succeed entirely in avoiding reference to psychological states, as one can see from a glance at the chapter headings.

The book is divided into two parts, the first part being devoted to a study of action and the second to a consideration of the ends which conduct strives to attain and of the means by which these ends are compassed. The thorough systematization which the author has succeeded in achieving is very striking and is especially evident in the first half of the book. Thus the subject of the varieties of human action is embraced in eleven sets of contrasting pairs as follows:

Action may be spontaneous or elicited; abundant or scanty; instinctive or reasoned; self-indulgent or self-restrained; impulsive or deliberate; voluntary or involuntary; novel, habitual, or automatic; orignal or imitative; crude or elaborate; work or play; skillful or unskillful. Naturally any single act may exhibit qualities from several or all of these contrasted couples.

The detailed consideration of these varities of action is particularly illuminating because of the lucidity of presentation and the richness of concrete illustrations.

In the remaining half of the book, which comprises chapters VI to XXII inclusive, the ends and purposes and the various modifications of conduct are treated. There are chapters on directly self-conservative conduct and indirectly self-conservative conduct; on the nature of social conduct, with a discussion of the influence upon conduct of the mere existence of others and of the presence of others, of the attention and estimation of others, of their approval, liking, exercise of will, and example. Then follows a discussion of the action of others on ourselves, on others, on circumstances. Spontaneous social conduct, with a detailed consideration of patriotism, philanthropy, and spontaneous morality, is the subject of the next two chapters.

Then follow three chapters on social-racial and more specifically racial conduct, with a discussion of such topics as chastity, modesty, courtship, jealousy, marital, parental, and filial conduct. Chapters on recreative and aesthetic conduct, on investigation, and on religious conduct complete the book.

This extremely rich content of Mercier's book leaves one, however, with a feeling of partial satisfaction only, in spite of its apparent completeness, and this feeling is undoubtedly due to the fact that the very suggestive contributions of analytic psychology are given no consideration in the book.

One must look for Mercier's attitude towards the analytic school of psychology in a more recent book of his on crime and criminals, published this year.

In speaking of the theory of the unconscious, on page 41, he says, "It is obvious that a state of mind that is unconscious is not a state of mind, any more than a solid body that offers no resistance is a solid body. It is nothing. The words are without meaning." This is followed by a bitter denunciation of psychoanalytic practice. But in

spite of this regrettable attitude of the author towards the Freudian school, his book will be found to be exceedingly helpful for a systematic orientation in the field of human conduct, albeit overt conduct.

BERNARD GLUECK.

DISPENSARIES: THEIR MANAGEMENT AND DEVELOPMENT. By Michael M. Davis, Jr., Ph.D., and Andrew R. Warner, M.D. New York: The Macmillan Company, 1919. 438 pp.

Medical officers returning from the army, where many for the first time had an opportunity to work in a large organization and where, strangely enough, many for the first time had brought forcefully to their attention the social aspects and responsibilities of their profession, are showing a greater interest in community problems and in the possibilities of professional "team play" in solving those problems. A medical officer could not stand in an examining line day after day, while thousands of youths passed him, and man after man was thrown out for what might in all truth be called inexcusable defects, without sooner or later having ring in his ears the words "neglect," "unnecessary," "carelessness," "ignorance." He could not walk his wards month after month, seeing men desperately ill get well and men crippled apparently beyond repair regain a more than reasonable amount of efficiency—because of an organization that permitted accomplishment and a pervading spirit that defied the impossible—without remembering civilians in much less desperate straits who die or lose efficiency through neglect or failure to obtain early diagnosis and advice, and industrial cripples left stranded because of lack of interest and of organization in caring for them. He could not live the life of a soldier in cantonment, observing the alertness, expertness, and success of his brother officers, the epidemiologists, in guarding every avenue of infection to the camp, without recalling the weakened defenses in his home community. He could not lose his resentment at having his ward placed next to the neuropsychiatric ward, as he found that in no way did this ward disturb his own, without sooner or later coming to wonder why such reasonable methods of care for nervous and mental patients are not used in civil hospitals—why, in his city of five hundred thousand, patients are jailed or neglected until they become a more or less total loss and a permanent charge upon the community when in a military city of forty thousand or twenty-eight thousand similar patients are, with a simple equipment, cared for at the beginning of their illness and helped and restored. He could not see a listless, gloomy ward transformed by the entrance of the occupational-therapy worker without thinking of his idle, restless, discouraged hospital patients at home. He could not have record after record made clearer through the information brought to him by the social worker without recalling his civil mistakes due to lack of just such information. In other words, with the evidence before them, month after month, of the

impossible accomplished through organization, expertness, coöperation, and "team play," many medical officers were brought, as it were, upon a mountain where, in the presence of a vision, they shed much of their "individualism."

But not only did medical officers see and think deeply upon these things. Nurses, social workers, Red Cross workers, and many others who in one way or another came into contact with the medical organization in the army, saw too, and, returning, are aware as never before of the desirability and the possibility of "organizing for health." In consequence there is a stirring throughout the country such as has never been known before. Cities and states are examining into their condition and planning for the future. Health centers are being discussed and in some places organized. Formerly well established clinics are extending their activities. New clinics are rapidly being established.

At this opportune time, when many physicians and lay assistants are enthusiastically entering a field that is more or less new to them, when plans of method, of organization, of administration must be considered, comes this book on dispensaries by Doctors Davis and Warner. It is an excellent book. There is not a chapter but contains material that will be of value to some earnest, but puzzled worker.

The authors state their object as threefold: "First, to depict briefly the history and present extent of dispensaries in the United States; second, to present the practical details which all people, including superintendents, physicians, nurses, and social workers, who are working in dispensaries particularly need to know; three, to present the dispensary as a form of organization, not only for rendering efficient medical service to the people, but to benefit the medical profession by stabilizing the economic position of the average physician," and it can be said that each object is reasonably attained.

It is a privilege to be able to call attention to this book, and it is to be hoped that it will be generally read by those who are planning community clinics.

FRANKWOOD E. WILLIAMS.

A STUDY OF THE MENTAL LIFE OF THE CHILD. By H. Von Hug-Hellmuth, M.D., Washington: Nervous and Mental Monograph Series No. 29, 1919. 154 pp.

Works on child psychology are apt either to be of anecdotal interest or to overdo unproductive analysis of special functions; the psychologist, whether dealing with the child or the adult, has as a rule fought shy of some of the most important determinants of human behavior, especially the sexual instinct. This shyness of the child psychologist has tended to sterilize his special branch of psychology. It is, therefore, gratifying to find a work in which the author is willing to give full value

to factors too long neglected, and to discuss the actual life of the child without embarrassment.

Unfortunately the author rather overshoots the mark and not only discusses frankly the rôle of the sex instinct in the child's life, but insists on interpreting in sexual terms many sources of pleasure the relation of which to sex is extremely doubtful. The lay reader, not skilled in discounting accurately this overemphasis on sex, is apt either to lay the book down in alarm or to swallow it uncritically as a wonderful revelation.

The book is worth careful study, for in spite of grotesque exaggerations here and there, it is full of valuable observations and gives a picture of child life that in many ways is more stimulating and of more practical help than the usual books on child psychology. The translating has been admirably done.

C. Macfie Campbell.

Broken Homes. By Joanna C. Colcord. New York: Russell Sage Foundation, 1919. 208 pp.

The problem of desertion of the family is one that is a little difficult to treat as a special topic, as it always occurs in such a complicated setting. No single formula can be supplied for it, no general principles will cover adequately the complexity of the individual cases. Social workers, however, find the topic bulking so largely in their work as to deserve separate consideration.

In this book Miss Colcord gives an excellent discussion of the whole problem. She emphasizes its complexity, and keeps always before the reader the necessity of thinking in terms of the concrete situation. The book is based upon detailed case-work; the various causes which have been found to be operative in desertion are discussed in a very satisfactory way. The practical steps to be taken in regard to the situation are gone over with a full realization of the complexity of the problem.

The book is written in excellent style, and throughout the author shows very good judgment in her discussion of the various problems.

C. Macfie Campbell.

Mortality Statistics of Insured Wage Earners and Their Families. By Louis I. Dublin, Ph.D., with the collaboration of Edwin W. Kopf and George H. Van Buren. New York: Metropolitan Life Insurance Company, 1919. 397 pp.

This volume gives an analysis of the 635,449 deaths among the policy holders of the industrial department of the Metropolitan Life Insurance Company during the period 1911 to 1916. It constitutes a comprehensive treatment of the entire field of mortality as related to wage earners and their families.

It was found that the general annual death rate per 1,000 persons exposed was 11.81; among the white the rate was 11.04 and among the colored 17.22; among the white males it was 11.22 and among the white females 10.40; among the colored males it was 17.63 and among the colored females 16.89. A comparison of mortality from all causes among white males and colored males, classified according to age, shows that there is a higher death rate among colored male wage earners during each age period. The difference in rate is greatest in the age group 20 to 24. There is likewise a higher death rate among colored females than among white females at each age period. The difference is very marked between the ages 15 to 65. Comparing the death rates of the several years covered by the study, we find that the general death rate declined from 12.53 in 1911 to 11.68 in 1916. The rate among the white males declined from 12.58 to 11.83; among the white females from 11.11 to 10.21; among the colored females from 17.50 to 16.85. The rate among the colored males increased from 17.42 in 1911 to 17.68 in 1916.

The influence of the principal diseases on the general mortality rate is carefully analyzed, a chapter being devoted to each of the diseases that cause a high percentage of deaths.

Tuberculosis, in all its forms, accounted for 110,363 deaths, or 17.4 per cent of the 635,449 deaths in the entire industrial mortality experience for the six-year period 1911 to 1916. Of these deaths, 93,526 were caused by tuberculosis of the lungs. The death rate among the colored from tuberculosis was more than twice as great as that among the white wage earners. A ray of encouragement is noted in the decline of the death rate from tuberculosis per 100,000 from 203.0 in 1911 to 172.8 in 1916. The rate among the white males declined during this period from 210.4 to 178.1; among the white females from 148.4 to 122.8; among the colored females from 375.1 to 336.8. Among the colored males the rate increased from 378.7 in 1911 to 386.8 in 1916. The low rate among white females in 1916 is especially noteworthy.

The deaths classified as due to organic diseases of the heart are second in numerical importance to tuberculosis in this mortality experience of insured wage earners. Of the 635,449 deaths, 75,345, or 11.9 per cent, were reported as due to organic cardiac diseases. The general death rate from these diseases per 100,000 was 140.1. Among white males it was 125.9; among white females 137.0; among colored males 191.0, and among colored females 202.0. An analysis of these deaths by ages shows that the rates are comparatively low up to the age of 35. From that time they increase very rapidly. Among the white a decline in the death rate from cardiac diseases from 1911 to 1916 is noted, while among the colored an increase in rate is noted during the period.

The third most prominent cause of death among the wage earners studied was pneumonia, a total of 57,931 deaths being reported as due

to some form of this disease. Of these 41,707 were due to lobar and undefined pneumonia, and 16,224 to broncho-pneumonia. The general death rate per 100,000 from lobar and undefined pneumonia was 77.5; among the white males the rate was 82.6; among the white females 63.0; among the colored males 141.5; among the colored females 97.2. The general death rate from lobar and undefined pneumonia decreased from 89.2 in 1911 to 80.8 in 1916. In 1915, however, the rate was 74.4.

The fourth most important cause of death found in this study was "Bright's disease," which term includes chronic interstitial nephritis, chronic parenchymatous nephritis, chronic diffuse nephritis, and nephritis undefined. It does not include acute nephritis. A total of 52,067 deaths were reported as being due to these causes. The general death rate per 100,000 was 96.8. Among white males the rate was 97.1; among white females 88.1; among colored males 138.7; among colored females 121.3. The general rate increased from 95.0 in 1911 to 99.0 in 1916. The increase was more marked among colored than among white wage earners.

External causes of death, including accidents, suicides, and homicides, accounted for 50,712 deaths among the group studied. The general death rate per 100,000 from these causes was 94.3. From accidents alone the rate was 73.0; from suicides 12.2; from homicides 7.0; from war deaths 2.1. An analysis of the mortality from various forms of accidents and injuries shows that the rate is very much higher among males than among females, and also that the rate from steam-railroad accidents and injuries is declining, while that from automobile accidents and injuries is increasing. Mortalities from street-car accidents and injuries from other vehicles excepting automobiles show a marked decrease during the six-year period. The figures compiled with reference to suicides seem to indicate a decline in the rate, but the authors call attention to the fact that suicide mortality is subject to considerable fluctuations with community conditions and that an opinion of the real trend of this phenomenon must be founded upon facts covering a long period of time and only after the fluctuations characteristic of suicide are in full view.

The study makes a very careful analysis of the various forms of cancer reported as causes of death. Altogether there were 37,666 of these cases. The death rate per 100,000 from cancer was 70.0. The rate among white males was 50.4; among white females 88.4; among colored males 31.0; among colored females 87.8. The figures compiled indicate a slight rise in the mortality rate from cancer from 1911 to 1916, but the authors state that "It is probable, though far from certain, that cancer mortality is not increasing."

Cerebral hemorrhage and apoplexy were assigned as causes of death in 36,638 cases. The average annual rate per 100,000 exposed was 68.1. The rate among the white males was 60.2; among the white females 69.5; among the colored males 76.9; among the colored females 97.4.

The figures show a decided jump in the rate from 1911 to 1912. Since 1912 the rate has apparently declined, but the change has been slight. In view of the difficulty experienced in securing uniform reports concerning this disease, the changes in rate indicated are not of great significance.

Reported deaths from syphilis, including locomotor ataxia and general paralysis of the insane, number 7,680. The combined death rate from these diseases was 14.3 per 100,000. The authors point out the fact that these figures represent an utterly inadequate measure of the incidence of syphilitic disease.

Several other forms of diseases are discussed in detail and figures are submitted to show the trend of mortality from each. The work throughout has been very carefully done and the presentation is most excellent. The work as a whole constitutes a very important contribution in the field of vital statistics.

HORATIO M. POLLOCK.

THE MENTAL HYGIENE OF CHILDHOOD. By William A. White, M.D. Boston: Little, Brown and Company, 1919. 193 pp.

Modern psychopathology is daily laying more and more stress on faulty development and is therefore assigning to the environment of the child a large share of blame for the nervous and mental diseases of adult life. Consequently intelligent parents are demanding literature which may give them the education necessary to meet these newly recognized responsibilities. The "Mind and Health Series" has met this demand in a timely way by giving us Dr. White's concise and simply written manual.

He begins, logically, with a definition of the child, exposing the unconscious fallacy which actuates so much ill-treatment of children, namely that the child is a little adult, whose mind works with grown-up mechanisms and is prompted by the same standards of conduct and ambitions as the parent's. Then follow five chapters in which he describes the instincts, instinctive development, and environment of the child. This is a frankly psychoanalytic exposition, but avoids the crudities and exaggerations found in many psychoanalytic writings. Some psychologists might dispute his categories, particularly the "Race Preservative (Sexual) Instinct." This is made to cover what are generally regarded as sexual tendencies, the bonds with society, and also all pleasure-pain impulses. Less gymnastics might be needed if the author were willing to postulate a herd instinct as well. The remainder of the book, apart from a chapter on the history of social treatment of the child, is concerned with the problems of education, punishment, sexuality, repression, and play. This second section deals admirably with the problems raised by the psychoanalytic theories of the first part of the book. So far as the reviewer is aware, no one has as yet furnished us with any-

thing like as clear a set of generalizations for the guidance of teachers and parents.

But the book has one grave defect. It is too short. Its brevity accounts fully for two disabilities. The layman is not a clinician nor a psychologist. The readers of this work will be looking for help in guiding the development of normal, or relatively normal, children. It is a far cry from "Peter Pan" to the child depicted in the first chapters. The parent is apt, we fear, to regard this as a picture of the psychopathic child and not a likeness of her little innocent. Sympathetic study will show that the author has not lost his perspective, but that, crowded for space, he has stressed those features of childhood which are potentially malignant. Unfortunately, one cannot count on sympathetic studiousness, and first impressions may be accepted as fixed prejudices. Secondly, solutions offered for the problems presented are, perhaps, too vague for the inexperienced to assimilate. If the book had been twice the size and replete with examples of definite situations, its practical value would be increased many fold.

As it stands, however, it is invaluable. If one reader out of ten can appreciate the truth which is offered him, the next generation will be much happier and healthier than this. For instance if he can see how he has been indulging his own complexes, his own whims, while he thought he was training the child in the way he should go, all children under his authority will benefit hugely. If the author had done nothing but write the chapter on *The Function of the Parent*, he would have made the layman greatly his debtor.

JOHN T. MACCURDY.

MANAGEMENT AND MEN. By Meyer Bloomfield. New York: The Century Co. 591 pp.

The author of this book has a national reputation in dealing with questions of personnel. The present volume concerns the labor situation in England. It consists largely of material prepared for the *Saturday Evening Post* in the course of a visit to Great Britain for the purpose of studying British industrial developments. The text is a straightforward account, without literary pretensions, of what is happening—how the mass problems of mental adjustment are being met. Naturally, a dominant note is the demand by workers for a greater share in the management of industrial affairs and a discussion of the means by which this can be attained. The Whitley plan looms very large through the book in this connection. Great developments in coöperative purchasing are described. It is not anticipated that the readjustment will involve destructive upheavals.

Considerably over half the volume is occupied by an appendix, which reprints documents related in various ways to the labor readjustment

and goes further into the details of the matter than does the text itself. The appeal of the book is distinctly to those who are in immediate contact with the management of industrial personnel, and to their work it should prove a very helpful manual of suggestions.

F. L. Wells.

The Child's Unconscious Mind: The Relation of Psychoanalysis to Education. By Wilfred Lay, Ph.D. New York: Dodd, Mead and Company, 1919. 325 pp.

There can be no ambition more lofty than that which prompted the writing of this book, for no study could be more important than that which is discussed by the author. Any enlightened lover of his kind would admit that a thorough knowledge and control of the unconscious mind of the child of this generation would produce in the next a race free from our most grievous problems. Whether one agrees with the tenets of psychoanalysis or disputes them, he must admit that the object, at least, of the psychoanalyst's study—the instincts and their secret workings—is the prime factor in settling the fate of the human species. The ambition of the author is therefore commendable.

But his achievement cannot merit so much praise. The first half of the book is devoted to a tedious description of the *adult* unconscious mind and its workings. In places it is well illustrated with original examples, but in general much space is taken up with elaborate, academic formulations and efforts to ally dynamic psychological principles with hypotheses concerning the physical basis of emotions, which hypotheses are accepted as facts. The work is addressed to parents and teachers, who can not be expected to take a feverish interest in such abstruse speculations. After each principle is discussed, the author pulls himself up with a jerk, remembers his title, and states that all this begins in childhood. In the second half, he is more interesting when he discusses the educational implications of psychoanalytic theories. He makes a number of good, practical suggestions, but each can easily be seen to be the product of common sense and sympathy. Wherever he attempts to apply his "science," he becomes hopelessly vague, directing a recognition and treatment of individual unconscious tendencies which could be unmasked only by a tedious individual analysis. He must be credited, however, with one—and an outstanding—virtue. He constantly inveighs against the current systems of education which look on individualism in taste as naughtiness and individualism of conduct as pure immorality. If the parent or teacher who plows through these many pages can glean but this one point and study anomalies before attempting to correct them, the book will have justified itself.

In conclusion it may be well to point out that the author is not alone in his guilt of discussing primarily the mind of the adult rather than that

of the child. So far as the reviewer is aware, only one extended analysis of a child has ever been published, and that many years ago by Freud. The implications of psychoanalysis unquestionably point to the origin of unconscious tendencies in childhood, but *children* have never been adequately studied. The few works extant describe a life grotesquely full of morbid sex fancies or else an idealized nursery where little angels laugh and sing. The truth presumably lies between, and it has not yet been given to us.

JOHN T. MACCURDY.

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STATEMENT

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THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
FRANKWOOD E. WILLIAMS, M. D., *Associate Medical Director.*

Sworn to and subscribed before me this 6th day of October, 1919.

M. A. FOWLER, *Notary Public.*

My commission expires March 30, 1920.
Form 3526.

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DIRECTORY OF SOCIETIES AND COMMITTEES FOR MENTAL HYGIENE

(Listed in the order of their origin)

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(Organized, May, 1908)
89 Church Street, New Haven, Conn.
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Mrs. Helen M. Ireland, Secretary

The National Committee for Mental Hygiene, Inc.
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50 Union Square, New York City
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401 Garrett Building, Baltimore, Md.
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The Louisiana Society for Mental Hygiene
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The Rhode Island Society for Mental Hygiene
(Organized, March, 1916)
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The Indiana Society for Mental Hygiene
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Paul L. Kirby, Secretary
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The Iowa Society for Mental Hygiene
(Organized, March, 1917)
Dr. Gershom H. Hill
Des Moines, Iowa

The Virginia Society for Mental Hygiene
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Petersburg, Va.

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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The National Committee for Mental Hygiene

Founded 1909

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CHIEF PURPOSES: *To work for the conservation of* [illegible] *the study of mental disorders and mental defects in all their forms and relations; to obtain and* [illegible] *concerning them; to help raise the standards of care and treatment; to help coördinate existing* [illegible] *and to organize in every state an affiliated Society for Mental Hygiene.*